

S. HRG. 108-836

**THE FINAL REPORT OF THE DEPARTMENT
OF VETERANS AFFAIRS CAPITAL ASSET
REALIGNMENT FOR ENHANCED SERVICES
COMMISSION**

HEARING

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE**

ONE HUNDRED EIGHTH CONGRESS

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TUESDAY, MARCH 2, 2004

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3:02 p.m., in room S-207, United States Capitol, Hon. Arlen Specter, Chairman of the Committee, presiding.

Present: Senators Specter, Hutchison, Graham, Rockefeller and Murray.

**OPENING STATEMENT OF HON. ARLEN SPECTER,
U.S. SENATOR FROM PENNSYLVANIA**

Chairman SPECTER. Good afternoon, ladies and gentlemen. The hearing of the Senate Veterans' Affairs Committee will now proceed. We regret the inconvenience in moving from our scheduled hearing room in the Russell Senate Office Building. As you know, we are in a series of votes in the Senate and rather than postpone the hearing, it seemed preferable to reschedule for this room where Senators can exit and vote and come back. We are now in the middle of two of four votes this afternoon, after having voted three times this morning. The Senate votes take priority over just about everything else.

We are proceeding today with an examination of the CARES Commission report, a very important report on the changes in providing medical care to America's veterans. We are facing a very difficult situation with veterans' care, with the current budget proposals probably requiring a cut, at least on their face as they have been submitted by the Administration. And that is in the face of a recommendation by the Secretary of Veterans' Affairs for an increase of some \$1.3 billion.

We will have to sort all of that out in the budget process, but I think there is determination in the Congress that there not be a reduction in the quality of medical care for America's veterans. We are facing a difficult situation internationally with the war in Iraq and the remnants of a war in Afghanistan and servicemen scattered around the world fighting terrorism, and a large detachment in South Korea.

The President has proposed a 7-percent increase in the Defense budget and about a 10-percent increase in the Homeland Security

budget. There is a direct correlation between defense and veterans' care at a time when there is an effort made to recruit young men and women to be put in harm's way, a very grave problem. It is hard to recruit if the young men and women who are being asked to enlist do not see that the veterans are being treated well.

With respect to the CARES Commissions' proposals, this Committee will make its facilities available to all Members of the Senate beyond those who are on the Committee to raise questions about proposals that might affect hospitals in their own States. Earlier today, I talked to the Ranking Member, Senator Graham of Florida, and his colleague, Senator Nelson, about a field hearing that they want to have in Florida and I have said that that would be authorized by the Committee.

The Committee will have field hearings in Pittsburgh, Altoona and Erie. If other Senators, even those not on the Committee, want to have field hearings, we are prepared to find out exactly what is going on. We are determined that there will not be a reduction in health care available to America's veterans. If it is a substitution of different forms of CARE, and if the substitutes are adequate or superior, then this Committee will entertain them.

We know that the issue has to be passed upon by the Secretary of Veterans' Affairs, and that this decision will, of course, be subject to review by this Committee. The final word will be up to the Congress as to what will happen.

We have a great many witnesses, but we have Senators here who doubtless want to say something, if it could be brief.

Senator Murray, in order of arrival, would you care to make an opening statement?

**OPENING STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON**

Senator MURRAY. Thank you Mr. Chairman. I just want to welcome the witnesses today. Admiral Alvarez did an admirable job, I think, putting this together, but there are very, very deep concerns in most of our States where this is being effected.

I have sent a letter to Secretary Principi regarding the Walla Walla facility. I do have some questions I want to ask you about when we get to that comment period. But, Mr. Chairman, I was pleased to hear you mention field hearings. I hope that Washington State can be considered for that. We are going to have a very huge impact from this. There is a lot of concern generated.

Chairman SPECTER. Senator Murray, if you want a field hearing in Washington, you have got it.

Senator MURRAY. Thank you very much, Mr. Chairman.

Chairman SPECTER. I was a little in doubt as to whether to go first to Senator Murray, who arrived first, or to the longer-serving Senator who was Ranking Member and Chairman of this Committee. I opted for Senator Murray, but now I turn to you, Senator Rockefeller.

**OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
U.S. SENATOR FROM WEST VIRGINIA**

Senator ROCKEFELLER. I am going to be very, very brief.

Chairman Alvarez, we welcome you and all of your colleagues from the CARES Commission. You should know and not be surprised by the fact that in West Virginia, which is a land that has about 4 percent of our land which is flat and 96 percent which is going uphill or downhill, and that all people, all industries, all activity has to take place in that 4 percent virtually, the closing of the Beckley hospital is painful. Any closing is painful. This one is very painful.

Our delegation is disappointed with the recommendations. We strongly disagree with your conclusions, but we respect what you have to go through and understand that tough decisions have to be made.

I will only say, Mr. Chairman, that you have established some key factors, principles, including how will this affect veterans' access to health and the quality of care; what are the views of the veterans stakeholders in the area and how do you know their views; and what about the effect on the local community and what are the costs to the VA; and, in addition, are there places that they could go for health care.

So I will be discussing and questioning a couple of those points, but I very much appreciate the Chairman's indulgence and your presence.

Chairman SPECTER. Thank you very much, Senator Rockefeller.

Our first witness is the distinguished Chairman of the CARES Commission, the Honorable Everett Alvarez, a distinguished Naval officer and Government executive best known as the first American aviator shot down over North Vietnam. He was taken prisoner of war and held in North Vietnam for some 8½ years. He has a J.D. degree from George Washington University School of Law. He has served as Deputy Director of the Peace Corps and Deputy Administrator of the VA from 1982 to 1986.

Thank you, Chairman Alvarez, for your distinguished service in so many capacities. We have a procedure established for a 5-minute time period, which will give the maximum amount of time to Senators for Q and A, and we do have a large number of witnesses. So we look forward to your testimony. You may proceed.

STATEMENT OF HON. EVERETT ALVAREZ, JR., CHAIRMAN, CARES COMMISSION, ACCOMPANIED BY: HON. R. JOHN VOGEL, VICE CHAIRMAN, CARES COMMISSION; AND RICHARD MCCORMICK, CARES COMMISSION

Mr. ALVAREZ. Thank you, Mr. Chairman and Members of the Committee. Mr. Chairman, my formal testimony has been submitted and I ask that it be accepted for the record.

Chairman SPECTER. Your full statement will be made a part of the record, without objection.

Mr. ALVAREZ. Mr. Chairman, I am pleased to be here today on behalf of the entire CARES Commission to present the CARES Commission report. With me today are two other members of the CARES Commission here, our Vice Chairman, John Vogel, on my immediate left, and Commissioner Dr. Richard McCormick, on my right. Also, behind me is Commissioner Charles Battaglia, who will be available to answer any questions.

Mr. Chairman, I come before you today representing the CARES Commission. We are 16 individuals with broad experience in health care and veterans advocacy. I can attest that the commissioners recognized the enormity and importance of their task, which was to critique and modify a blueprint for enhancing the health care of as many veterans as feasible into the future. And let me emphasize that point, sir. The commission views the draft National CARES Plan as a blueprint for VA health care for the next 20 years.

Health care delivery in this country is changing. VA's health care delivery is under change and this change needs to be managed carefully and respectfully. The commission sees its blueprint as a road map to the future, a tool to help manage future change.

Within the time constraints, the commission evaluated an enormous amount of data. We listened to many veterans, providers of care and stakeholders. We had 81 site visits and we held 38 public hearings across the country, and focused our collective experience on the task.

Our report, which you have, is large and far-reaching. It includes important discussions and recommendations on issues that cut across the entire VA health care system. It also includes hundreds of site-specific recommendations. If the plan is to succeed in its goals, priorities still need to be attended to and properly aligned. Evaluations still need to be conducted for important components of VA health care, and internal processes need to be overhauled.

I wish in these opening remarks to share the principles that served as a beacon to guide us through our complex deliberations.

First and foremost, to improve access to as many veterans as possible to high-quality, veteran-specific health care. The VA facilities were largely built 40 to 50 years ago. The population demographics have shifted. The delivery of health care has increasingly become an issue of access both for veterans and their families, who need to partner in their care.

Cost of efficiency. When, as is the case today, the health care needs of some veterans are unfulfilled, particularly for the highest-priority veterans with war-related physical and mental disabilities, then efficiency is also an issue of access and quality of care. If we do not use resources as efficiently as we can, some veterans in dire need of services may not receive the care they need or deserve. Therefore, the commission also looked at the cost/benefit of each recommendation. We recognize that the costs that were provided were often in need of further refinement, forcing us to consider the likelihood, based on past experience in VHA and a test of reasonableness, that an action would improve efficiency.

The impact of change in the status quo on current recipients of services, current VA employees and the communities where our facilities have been historically located was another key principle that guided the commission. The commission recognizes that the shifting of resources necessary to improve overall access will be a hardship for some. We expect that the implementation of necessary change will take this into account when time lines for modifications are finalized.

The commission's recommendations are our assessment of what is best for VA health care as we move forward. We are not infal-

lible. Things will change over time and there may be factors that need to be reconsidered. However, this is our best effort.

We look to the Secretary and to the Congress to further refine and improve upon our assessment, keeping, we hope, in their focus the principles that have guided our deliberations to provide access to high-quality health care to as many veterans as our resources permit.

Mr. Chairman and Members of the Committee, I would like to thank you for the opportunity to address you. My fellow commissioners and I look forward to your questions, and an ongoing dialog, we trust, will move all of us closer to our jointly held goal to serve those who have and are serving our country.

Thank you, sir.

[The prepared statement of Mr. Alvarez follows:]

PREPARED STATEMENT OF HON. EVERETT ALVAREZ, JR.,
CHAIRMAN, CARES COMMISSION

Mr. Chairman and Members of the Committee, good afternoon. I am pleased to be here today on behalf of the entire Commission, to present the Capital Asset Realignment for Enhanced Services (CARES) Commission's Report. With me today are Vice-Chairman John Vogel, and Commissioners Mr. Charles Battaglia and Dr. Richard McCormick.

The Commission's journey began in February, 2003, when The Honorable Anthony J. Principi, Secretary of Veterans Affairs, asked the Commission to provide specific impartial and equitable recommendations for realignment and allocation of capital assets to meet the demand for veterans health care services over the next 20 years. As you know, Sir, the goal of CARES is to enhance services, not to save money—but to spend appropriated funds wisely. In fulfilling our obligation to Secretary Principi, to veterans and their families, to stakeholders and partners, and to the dedicated VA staff, Commissioners:

- Visited 81 VA and Department of Defense medical facilities and State Veterans Homes;
- Held 38 public hearings across the country, with at least one hearing in each Veterans Integrated Service Network (VISN);
- Held 10 public meetings;
- Analyzed more than 212,000 comments received from veterans, their family members, and stakeholders.

At the public hearings, the Commission had the opportunity to hear from approximately 770 invited local speakers, including VISN leadership, veterans, veterans service organizations, State directors of veterans affairs, local labor organizations, medical and nursing school and other allied health professional affiliates, organizations with collaborative relationships, and local elected officials. Seven Governors and 135 Members of Congress participated or provided statements for Commission hearings.

The CARES Commission Report is the compilation of information gathered at these site visits, public hearings, and meetings as well as information obtained from the public comments and VA. It represents the best collective judgment of the Commissioners, who applied their diverse expertise in making decisions related to the future of VA's infrastructure. I would like to emphasize, Mr. Chairman, that the focal point of the Commission's effort and report is enhancing access to health care for America's veterans while ensuring that the integrity of all VA missions is maintained, and any adverse impact on VA staff and affected communities is minimized.

COMMISSION APPROACH

Mr. Chairman, to assess the reasonableness of each proposal in the Draft National CARES Plan, the Commission developed and applied the following factors:

- Impact of veterans' access to health care
- Impact on health care quality
- Veterans and stakeholder views
- Economic impact on the community
- Impact on VA missions and goals, and
- Cost to the Government

In applying these factors, the Commission evaluated each proposal using available data and written analysis submitted by each VISN and by VA's Under Secretary for Health, Dr. Robert Roswell. The Commission's recommendations are based on this evaluation and the knowledge gained through the Commission's study of VA's infrastructure and health care system.

NATIONAL CROSSCUTTING ISSUES

Through the public meetings, site visits, hearings and informal meetings with individual veterans and stakeholders, the Commission developed a deeper appreciation for the complexity of the system-wide issues confronting VA and the significance of the changes proposed in the Draft National CARES Plan. The Commission identified a variety of issues that are critical to VA's success as it continues to realign and transform its health care system. The Commission believes that resolution of these national crosscutting issues is essential to achieve the changes the Secretary desires and to accomplish CARES goals for enhanced services to veterans.

The Commission identified six national crosscutting issues. These are:

1. Facility Mission Change
2. Community-Based Outpatient Clinics
3. Mental Health Services, which includes acute inpatient and outpatient services
4. Long-Term Care, including geriatric and seriously mentally ill services
5. Excess VA Property
6. Contracting for Care

The Commission determined that for VA to reach a successful outcome from the CARES process, it was essential that recommendations be developed for these crosscutting issues. These issues and related recommendations, while appearing at times to be discrete from one another, are in fact interdependent, and require careful integration. For example, facility mission changes and managing excess property concentrate on the realignment of capital assets. The prioritization and placement of community-based outpatient clinics and contracting for care in local communities focus on developing equitable access to quality health care. Similarly, the issues of mental health services and long-term care deal with providing access to quality services.

Recommendations on the national crosscutting issues served to guide the Commission's decisionmaking as it reviewed the VISN-specific proposals in the Draft National CARES Plan. The Commission believes that these crosscutting recommendations should be the basis for developing national policy guidance.

Mr. Chairman, I would now like to discuss each of the six national crosscutting issues.

1. FACILITY MISSION CHANGES

The intent of the CARES process is to realign resources in order to enhance access to health care services for our nation's veterans. To accomplish this goal, it is critical to eliminate duplicate clinical and administrative services at VA facilities, increase efficiencies, and allow reinvestment of financial savings.

The Draft National CARES Plan proposed consolidation of services at 40 facilities—18 with small workload volumes ("small facilities") and 22 within close geographic proximity of other facilities ("proximity") or with multiple campuses ("campus realignment"). Of the 18 small facilities, the Draft National CARES Plan identified seven facilities that would convert to a new type of facility modeled after the Centers for Medicare and Medicaid Services designation of a critical access hospital. The Commission used the term "facility mission changes" to describe all recommended changes to facilities.

As mentioned earlier, the Commission applied specific factors in its evaluation of each mission change proposal to assess the proposal's reasonableness. In applying these factors, the Commission relied on the broad expertise and experience of the Commission members. Further, due to a lack of supporting data for the Draft National CARES Plan's proposals on facilities with a potential mission change, the Commission evaluated each facility using its own factors, taking into consideration the unique issues in the various VISNs and issues associated with urban and rural areas, and utilized data in a number of areas such as past, present and projected VA workload; whether there were alternative community resources, costs; quality of care; and financial analyses. I should emphasize, Mr. Chairman, that the Commission considered access and quality of care to be the primary drivers in meeting the health care needs of veterans.

Mr. Chairman, if I may, I would like to address the Commission's recommendations on those facilities with a potential mission change where the Commission did not concur in whole or in part with the Draft National CARES Plan.

Before I do, Sir, I will say that the Commission did not concur with the Draft National CARES Plan's proposal designating seven medical facilities as critical access hospitals primarily because VA had not established a clear definition or clear policy on the critical access hospital designation prior to making decisions on the use of this designation. We understand, however, that the Under Secretary for Health has assembled a team of experts and a draft definition has been developed. The Commission has not evaluated this newly developed definition.

VISN 1—Bedford, Massachusetts: The Commission did not concur with the change in mission at Bedford. The Commission recommended a more thorough study of the feasibility of building a single, replacement medical center in the Boston area.

VISN 2—Canandaigua, New York: The Commission concurred with transferring acute inpatient psychiatry beds and that Canandaigua retain its ambulatory care programs. The Commission recommended that Canandaigua retain long-term care, including the nursing home, psychiatric nursing home care and the domiciliary. The Commission also recommended that the VISN develop another strategic plan for the challenges it faces in Canandaigua with high overhead costs, unused or underutilized buildings, and the impact on the community and employees and that the VISN involve stakeholders and the community to resolve these issues.

VISN 3—Montrose, New York: The Commission recommended that the inpatient psychiatry beds and nursing home care beds be moved from the Montrose campus to the Castle Point campus and that the domiciliary-based residential rehabilitation programs and the ambulatory care services remain at the Montrose campus.

VISN 3—Castle Point, New York: The Commission concurred with the proposal to transfer the spinal cord injury beds to the Bronx. The Commission did not concur with designating the facility a critical access hospital.

VISN 4—Pittsburgh, Pennsylvania—Highland Drive Division: The Commission concurred with the proposal to consolidate services at the Highland Drive Division of the Pittsburgh Health Care System with the University Drive Division and the Heinz Progressive Care Center. The Commission, however, recommended that VA conduct an improved life cycle cost analysis.

VISN 4—Erie, Pennsylvania: The Commission concurred with the proposal to close inpatient surgical services at the Erie VA Medical Center and retain outpatient services (including outpatient surgery) and long-term care programs. The Commission did not concur with the proposal that Erie maintain the remainder of its current inpatient services and recommended that all acute care beds be closed as soon as reasonable. The Commission also recommended that VISN 4 continue its referral practices to the Pittsburgh Health Care System for Erie area veterans and that the VISN pursue available resources in the Erie community.

VISN 4—Altoona, Pennsylvania: The Commission concurred with the proposal that the Altoona VA Medical Center maintain its outpatient services, as well as its long-term care programs. The Commission did not concur with the proposal to close Altoona's acute care services by Fiscal Year 2012 and recommended that acute care beds be closed at Altoona as soon as reasonable. The Commission also recommended that VISN 4 continue its referral practices to the Pittsburgh Health Care System for Altoona area veterans and that the VISN utilize available resources in the Altoona community.

VISN 6—Beckley, West Virginia: The Commission did not concur with the proposal to convert the Beckley VA Medical Center into a critical access hospital and recommended closing the acute inpatient hospital beds and contracting for acute inpatient care in the community as soon as reasonable. The Commission also recommended that the Beckley VA Medical Center retain its multi-specialty outpatient services and the nursing home.

VISN 7—Augusta, Georgia—Uptown Division: The Commission did not concur with the proposal to study the feasibility of consolidating selected current services at the Uptown Division to the Downtown Division because we found the proposed realignment to be impractical.

VISN 8—Lake City, Florida: The Commission did not concur with the proposal to move inpatient surgery services at the Lake City VA Medical Center to the Gainesville VA Medical Center at the present time. In light of the projected growth of enrollees and the access gap in the North Market of VISN 8, the Commission recommended that any consideration of transfer of inpatient services from Lake City to Gainesville be delayed until after Fiscal Year 2012. The Commission concurred with the proposal to maintain nursing home care and outpatient services at the Lake City VA Medical Center.

VISN 9—Lexington and Leestown, Kentucky: The Commission did not concur with the proposal to transfer current outpatient care and nursing home care services from Leestown to Cooper Drive. The Commission recommended that the Lex-

ington-Leestown campus remain open and continue to provide nursing home, outpatient care, and administrative services.

VISN 10—Cleveland, Ohio—Brecksville Campus: The Commission concurred with the proposal to relocate current psychiatric care, nursing home care, domiciliary, and residential services from the Brecksville Campus to the Wade Park Campus, provided the existing level of services can be maintained. The Commission also concurred with the proposal to pursue enhanced use lease opportunities at Brecksville in exchange for property adjacent to Wade Park.

VISN 11—Saginaw, Michigan: The Commission concurred with the proposal to discontinue acute medical services at the Saginaw VA Medical Center. The Commission also concurred with the proposal to maintain the nursing home and outpatient care at the Saginaw VA Medical Center.

VISN 15—Poplar Bluff, Missouri: The Commission recommended that a target date be set for making a full cost-benefit analysis for sustaining inpatient services at the Poplar Bluff VA Medical Center versus contracting for such services. The Commission further recommended that, based on the results of that assessment, a decision be made regarding whether or not to close inpatient services at Poplar Bluff. The Commission does not concur with designating the facility a critical access hospital.

VISN 16—Muskogee, Oklahoma: The Commission concurred with the proposal to close inpatient surgery and intensive care unit beds at the Muskogee VA Medical Center and that ambulatory surgery should continue with surgery observation beds. The Commission recommended that a more thorough study be conducted of meeting health care needs of the population through the Muskogee VA Medical Center versus using community resources in the Muskogee/Tulsa area. A target date should be set for completion of this study. In the short term, inpatient medical services should be sustained. Expansion of inpatient psychiatry should await the results of the study.

VISN 17—Waco, Texas: The Commission concurred with the proposal to transfer services from the Waco campus to appropriate locations within the VISN as follows: (1) a portion of acute care inpatient psychiatry to Austin; (2) the balance of acute care and all the long-term inpatient psychiatry to the Temple VA Medical Center; and (3) post-traumatic stress disorder residential rehabilitation services to the Temple VA Medical Center, with no decrease in capacity. The Commission concurred with the proposal to transfer the Blind Rehabilitation Center from Waco, but recommends that the VISN determine an appropriate location taking into account access and the Blind Rehabilitation Center's role as a regional rehabilitation referral center. The Commission concurred that a new multi-specialty outpatient clinic be established in the Waco area. The Commission did not concur with the proposal to transfer Waco's nursing home services to the community. The Commission recommended that time be provided for the transition to allow an orderly transfer with minimal disruption to patients and families and for the VISN to involve veterans, stakeholders, and the community in a plan for the Waco campus that is most beneficial to veterans.

VISN 17—Kerrville, Texas: The Commission concurred with the proposal to transfer the Kerrville VA Medical Center's acute inpatient services and recommends that the VISN contract with community health care providers for these acute inpatient services, including urgent care services, in lieu of or until space is available at the San Antonio VA Medical Center. The Commission concurred with the proposal that the nursing home and outpatient services remain at Kerrville. The Commission did not concur with designating the facility a critical access hospital.

VISN 18—Big Spring, Texas: The Commission concurred with the proposal insofar as it relates to studying the possibility of no longer providing health care services at the Big Spring VA Medical Center. The study should take into account the input of stakeholders regarding access to care. The Commission did not concur with designating the facility a critical access hospital.

VISN 19—Cheyenne, Wyoming: The Commission recommended that the Cheyenne VA Medical Center retain its current. The Commission did not concur with designating the facility a critical access hospital.

VISN 19—Grand Junction, Colorado: The Commission recommended that the Grand Junction VA Medical Center retain its current mission. The Commission did not concur with designating the facility a critical access hospital.

VISN 20—Vancouver, Washington: The Commission recommended maintaining the current mission at the Vancouver facility, while reducing the campus footprint. The Commission also recommended that VA explore options to expand Vancouver's function, particularly with regard to relocating services from the Portland VA Medical Center.

VISN 20—White City, Oregon: The Commission did not concur with the Draft National CARES Plan's proposal to transfer the domiciliary and Compensated Work Therapy programs from White City to other VA medical centers in the VISN. The Commission, however, agreed with the VISN-recommended alternative that the White City Southern Oregon Rehabilitation Center Clinic maintain its current mission. The Commission did concur with the Draft National CARES Plan's proposal to maintain outpatient services at White City.

VISN 20—Walla Walla, Washington: The Commission concurred with the proposal to close and, where appropriate, contract for acute inpatient medicine and psychiatry care and nursing home care in the Walla Walla geographic area. The Commission also concurred with the proposal to maintain outpatient services and recommended that outpatient care be moved off the Walla Walla VA Medical Center campus after inpatient services have been relocated.

VISN 21—Livermore, California: The Commission concurred with the proposal to transfer sub-acute beds to the Palo Alto VA Medical Center, and that outpatient care should be shifted to CBOCs. The Commission recommended that the nursing home beds at the Livermore VA Medical Center be retained as a freestanding nursing home care unit.

VISN 23—Hot Springs, South Dakota: The Commission recommended that the Hot Springs VA Medical Center retain its current mission to provide acute inpatient medical, domiciliary and outpatient services. The Commission did not concur with designating this facility a critical access hospital.

VISN 23—Knoxville, Iowa: The Commission concurred with the proposal to move all inpatient services to the Des Moines and to retain outpatient services at the Knoxville VA Medical Center.

2. COMMUNITY-BASED OUTPATIENT CLINICS

Following the VISN's submissions outlining the needs for additional CBOCs, the Under Secretary for Health developed criteria to organize proposed CBOCs into three priority groups. The Under Secretary indicated to the Commission that priority groups were established in order to constrain demand on the system. The Commission believed the Under Secretary's approach to determine priority groups has the effect of limiting access to outpatient care, which is contrary to the goal of CARES. It also had unintended consequences in that it inadvertently disadvantaged veterans in rural communities by generally placing CBOCs for rural areas in the second priority group because of the relatively small veteran populations in these markets. Further, the same population data used to propose a CBOC could be clustered in different ways yielding various results in the prioritization of CBOCs.

VISNs also proposed new CBOCs to address overall workload issues and space capacity issues at parent facilities and existing CBOCs. The Commission learned that several facilities are currently operating at and over capacity for outpatient care. Proposed CBOCs that address space issues associated with increased workload are in the third priority group. Without timely development of new sites of care, whether designated as CBOCs or otherwise, there will be greater demand on existing clinic space and examination rooms, leading to inefficient workflow and a reduction in the total number of patients that can be seen in a given day. This in turn could lead to increased wait times.

Some parent facilities also have projected growth in inpatient workload, requiring conversion of outpatient space back to its original inpatient purpose. Without the timely establishment of new CBOCs, many facilities will require construction to accommodate workload increases, a more costly solution with longer-term ramifications.

The Commission recommended that the Secretary and the Under Secretary for Health use their authority to establish new CBOCs with the VHA medical appropriations without regard to the three priority groups. Also, the Commission recommended that VISNs set priorities for new CBOCs based on VISN needs to improve access and to respond to increases in workload. Additionally, the Commission recommended that VISNs be able to establish new sites of care to reclaim space at the parent facility to meet increasing demand for inpatient care. Further, the Commission endorses the legislative requirement and VA policy to include basic mental health services in CBOCs, whenever feasible. Finally, the Commission recommended that VISNs collaborate with academic affiliates to develop learning opportunities using CBOCs as teaching sites to enhance quality of care in community-based service settings.

3. MENTAL HEALTH SERVICES

The care of veterans with mental disorders is a high priority component of VA's health care mission. Nearly a half million veterans have a service-connected mental disorder.

The National CARES Program Office recognized early in the methodology used to project mental health services did not accurately account for services provided by VA. As a result, the model projected decreasing requirements for outpatient mental health services while national projections included significant increases in outpatient primary and specialty care needs.

The Commission is pleased to learn that the National CARES Program Office has recently completed reworking enrollment forecasts for mental health services. Changes to the model included ensuring that VA actual workload and projected workload data are comparable and account for the needed mental health services for Vietnam Era veterans and those who follow, such as those serving in Iraq and Afghanistan. The Commission recommended that with the new projections, the VISNs develop plans to address gaps in mental health services and these plans should be integrated into the CARES process. As indicated in my earlier discussion, the Commission reinforced Congressional intent that basic mental health services should be provided in CBOC settings. Additionally, the Commission recommended that acute inpatient mental health services should be provided with other acute inpatient services whenever feasible.

4. LONG-TERM CARE

The Commission learned that long-term care, including nursing home, domiciliary and non-acute inpatient and residential mental health services, was not included in the current CARES projections due to the absence of an adequate model to project future need for these services. Nevertheless, the Draft National CARES Plan includes a number of initiatives that directly impact nursing home care, domiciliary care, and residential and long-term mental health care.

VA's nursing home care units vary in mission and case mix. Some operate as short-term medical rehabilitation units and some operate as traditional long-term care units. Some provide care for seriously mentally ill patients who also have care needs related to medical illnesses and dementia. The Commission noted that these patients are extremely difficult to place in community nursing homes, as most do not admit patients with severe psychiatric illness.

The Commission heard conflicting rationale for moving current long-term care beds. On the one hand, the Under Secretary for Health and certain VISN officials contended that long-term care beds should be located on the same campus as a tertiary care center to enhance overall medical care. Some proposals in the Draft National CARES Plan are consistent with that view. On the other hand, several proposals call for moving long-term care beds to campuses without medical beds, or for contracting with community nursing homes not connected to a hospital. The Commission noted that the norm for community nursing homes is that the nursing home facility is located away from facilities with medical services and, VA currently has nursing homes that are not located on the same campus as the medical center.

In addition, inconsistent views have been expressed by VISNs concerning the extent to which community nursing homes can adequately provide care for veterans with serious psychiatric needs. Some VISNs expressed a willingness to contract for all nursing home beds, while others argued strongly that a sizable portion of VA nursing home patients could not be adequately cared for in community nursing homes.

Due to the lack of an adequate model to project future need for long-term care services and because of the conflicting rationale for addressing long-term care needs in the VISNs, the Commission recommended that VA develop a strategic plan for long-term care services, including the long-term care for the seriously mentally ill. Additionally, the Commission recommended that long-term care facilities located away from the medical center campus should be accepted as a care model. Further, the Commission recommended that in developing a strategic plan, VA should consider broader collaboration with states to leverage VA and other public funding through the State Veterans Home programs.

It should be noted that although there is a need for VA to complete a strategic plan for long-term care services, the Commission observed existing long-term care facilities, primarily nursing home units, that have poor facility conditions or require infrastructure improvements resolve privacy and safety issues. Recognizing this, the Commission did not want to disadvantage current patients in VA's long-term care facilities and recommended that renovations to existing long-term care and chronic psychiatric care units be accomplished.

5. EXCESS VA PROPERTY

Much of VA's vacant space is not contiguous, but consists of pockets of space scattered throughout the campuses, making it useless for other purposes. The Commission also recognized that additional vacant space would be created through mission changes and consolidations. Further, there is an unspecified amount of acreage that is not currently in use and numerous properties in VA's inventory are historically important or have historic designations.

The Draft National CARES Plan outlines demolition and divestiture, particularly in the early years of the CARES implementation phase, as the primary methods to reduce current vacant space as well as vacant space that will be created through mission changes and consolidations. The Commission recommended that VA consider all options for divestiture, including outright sale and transfer to another public entity.

The Draft National CARES Plan also places significant reliance on the enhanced use lease process to address excess space or property. The Commission, however, has determined that the enhanced use lease process as currently structured is not effective.

Across the country, Commissioners consistently heard testimony on the structural problems with the enhanced use lease process. In the field, there often is insufficient expertise or resources to attract potential investors or to navigate local zoning and land use requirements. Within VA, the review and approval process is arduous and time-consuming. The Commission, therefore, recommended that the enhanced use lease process be reformed to ensure timely action on proposals and that VA develop a more efficient process, perhaps creating a separate organization to pursue disposal of excess VA property and land.

As previously stated, there are numerous historic properties in VA's inventory, many of which can no longer be used for medical care services. As with other types of excess property, VA must use medical care appropriations that could otherwise be used to provide direct medical care to pay for the upkeep and maintenance of property that no longer has a medical purpose. Rather than rely on medical care appropriations, the Commission recommended that VA seek a separate appropriation for historic preservation funds to stabilize and maintain historic property.

6. CONTRACTING FOR CARE

VA uses contracting as one vehicle for improving access to care and has significantly expanded access to care with CBOCs. The benefits of contracting for care in the community are it can add capacity and improve access faster than can be accomplished through a capital investment; it provides flexibility to add and discontinue services as needed; and it allows VA to provide services in areas where the small workload may not support a VA infrastructure, such as in highly rural areas.

The Commission concurs with the Draft National CARES Plan's proposal to utilize contracts for care in the community to enhance access to health care services. However, before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community. Additionally, the Commission recommends that the Secretary ensure that VA has quality criteria and procedures for contracting, and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

Mr. Chairman, there are six additional issues that are distinguished from these national crosscutting issues in that they are relevant in selected VISNs, rather than in most or all of the VISNs. These issues are no less significant to any other issues we reviewed and I would like to briefly address the recommendations for each of them.

1. Infrastructure and Safety

VA has identified 63 medical centers requiring seismic correction. Many of these medical centers are large facilities located in high population density areas. Of this total, the Draft National CARES Plan has prioritized 14 sites that require immediate seismic strengthening for a total funding requiring of \$560.8 million. The Commission recommended that Secretary Principi seek necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

2. Education and Training

Although VA has transformed from a primarily inpatient delivery model to a community-based outpatient delivery system, generally speaking, medical schools and other clinical affiliates have not made the transition from the traditional inpatient teaching modalities to incorporate community-based outpatient primary and specialty care delivery into their educational programs. The Commission, therefore, rec-

ommended that VA and its academic affiliates develop a plan to add a community-based outpatient component to existing and new education and training sites.

Additionally, in light of VA's significant involvement in nursing education and the dramatic impact the nursing shortage has on VA's ability to provide access to quality care for veterans, the Commission believes there is strategic value to formalizing the relationships between VA and schools of nursing. The Commission recommended that VA establish national policy guidance for schools of nursing comparable to the medical school model and actively promote nursing school affiliations, as well as affiliations with other health profession educational institutions.

3. Special Disability Programs

The Commission found that VA uses a hub and spoke model to care for spinal cord injury and disorder patients. Patients travel to the "hub" tertiary hospital for inpatient care or complex services. For more routine services, patients receive care at regional "spoke" VA medical centers. Similarly, VA's Blind Rehabilitation Centers are structured to serve blind veterans in an inpatient environment.

The addition of two blind rehabilitation centers in VISNs 16 and 22 will assist blind veterans throughout the country. The Commission believes inpatient settings are not the only solution, particularly because many blind veterans do not require a residential program. Rather, a more appropriate response to serving many blind veterans is to provide rehabilitation and retraining in community or home settings. As such, the Commission recommended that VA develop new opportunities to provide blind rehabilitation in outpatient settings close to veterans' homes.

For Spinal Cord Injury Centers, there is no strategic approach to balancing the mix of acute and LTC beds. The Commission believes the proposed addition of four spinal cord injury centers and additional beds in four other locations will benefit many veterans. The Commission, however, recommended that VA assess their acute and long-term spinal cord injury bed needs to provide the proper balance of these beds.

The Commission also recommended that VA coordinate among VISNs the placement of special disability centers to optimize access to care for veterans.

4. VA/Department of Defense (DoD) Collaboration

The Commission reviewed a wide range of VA/DoD sharing initiatives across the country and found varying degrees of support and momentum for their completion. At those sites with successful initiatives, the Commission noted a clear, mutual commitment to the value of the collaboration, dedication from the top local leadership to the making the collaboration work, and a sustained effort to monitor and manage the day-to-day activities. From its review, the Commission recommended that to ensure a successful collaborative relationship between DoD and VA, there must be clear commitment from their top leadership, both to the initial establishment of collaboration and to its ongoing maintenance, especially when there is a change in the local leadership.

5. Research Space

The Draft National CARES Plan includes more than 20 research leases, new construction and enhanced use lease. The Commission notes that VA has excelled in this core mission and, therefore, concurred with the proposals for enhancing research space.

6. Care Delivery Innovations

VA has undertaken a number of changes in care delivery designed to enhance access to services. Primary among them are CBOCs. However, the use of advanced practice nurses and telemedicine are two other illustrations of new approaches to delivering care.

Veterans reported a high satisfaction with the care provided by advanced practice nurses and access was clearly enhanced when wait times were reduced, services were brought closer to where veterans live, and continuity of care was enhanced.

The Commission also observed telemedicine to be an effective tool to enhance access to care and leverage clinician productivity especially for veterans living primarily in rural areas and in locations where specialty medical are not readily available.

The Commission recommended that VA use advanced practice nurses and telemedicine to enhance access and quality of care, and urges wider application of these resources throughout the system. Furthermore, the Commission believes that this does not have to be limited to only advanced practice nurses but should include other critical health care professionals such as pharmacists, physician assistants, and other health care team members.

CLOSING

Mr. Chairman, I have highlighted significant recommendations from the Commission's Report. I would like to conclude my testimony today by saying that there were cases where the Commission came to a different conclusion than the Draft National CARES Plan. However, the driving force for the VISNs and the Commission was enhancing medical services to veterans. The Commission strongly believes that it is good public policy that VA continue to integrate the CARES process into its planning, budget, and legislative cycles.

Mr. Chairman and Members of the Committee, I would like to thank you for the opportunity to address you. That concludes my formal remarks. My fellow Commissioners and I would be pleased to answer any questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. ARLEN SPECTER
TO THE DEPARTMENT OF VETERANS AFFAIRS

Question 1. Now that you have had the opportunity to review the CARES Commission's report and have seen how it differs from your Draft National CARES Plan, do you feel the Commission's report adequately meets the needs of all veterans? Do you have any reservations with respect to the Commission's rejection or modification of some of your recommendations?

Response. The CARES Commission undertook a monumental task in reviewing the Draft National CARES Plan and completing their task in the timeframe allowed them. After an intensive careful review of the Commission's findings and recommendations, VA is confident that they were carefully studied and are strategically sound. On May 7, 2004, the Secretary formally accepted the CARES Commission Report. He will, however, use the flexibility it provides to minimize the effect of any campus or service realignment on the continuity of care to veterans currently receiving services in those locations. The CARES Commission Report and the Secretary's decision document comprise a blueprint for VA's future that will effectively guide us forward. It will be VA's reference and initial point of departure for all future planning.

Question 2. The Draft National CARES Plan applied a "Critical Access Hospital" (CAH) designation to many small facilities that furnish acute hospital care in rural or less densely populated areas. The Commission was critical of that feature of your recommendations, stating that you had not developed a clear definition or criteria for the establishment of CAHs. What are your thoughts on the Commission's disagreement with your concept of initiating a CAH model in VA? Is VHA attempting now to clarify its conception of the CAH concept?

Response. The CAH concept is a framework used by the Centers for Medicare and Medicaid Services for assessing the future of small facilities. However it became apparent that we would have to customize this framework for VA small facilities. The DNCP indicated that "[o]ver the course of the next year, the VA will develop and implement policies to govern the operation of acute beds in small VA facilities, which may fit into a CAH-like model of health care delivery." We have begun that process and expect to complete criteria and policy for Veterans Rural Access Hospitals by July. The policy and criteria will adapt the CAH concept to the VA health care system.

Question 3. As you know, many of those older veterans rely heavily on prescription medications for daily health maintenance. The Draft National Plan and the Commission report include plans to add more Community Based Outpatient Clinics, but neither specifies plans to increase the number of Consolidated Mail Out Pharmacies (CMOP) to provide medications for these patients. Without new mail-out pharmacy space, how will VA handle an increased patient pharmacy load? Are you considering adding additional CMOP capacity?

Response. VA continues to increase the capacity of its existing Consolidated Mail Outpatient Pharmacies (CMOPs) by upgrading equipment, introducing State-of-the-art technology and disseminating best practices across the entire CMOP operation. During fiscal year 2004, these improvements are expected to increase capacity from 83.8 million to 93.8 million prescriptions per year (a 12 percent increase).

Additionally, VA has numerous initiatives planned that include the implementation of a central CMOP data base that will allow more efficient distribution of workload across VA's seven CMOPs. This will allow for dynamic data management in support of planned specialization of CMOP dispensing across all seven facilities, with a goal of maximizing productivity and efficiency. In addition, this allows for further use of direct-to-manufacturer outsourcing on difficult to process goods such as dietary supplements, which will allow VA to increase its prescription fulfillment capacity without additional capital investment.

During fiscal year 2004, VA expects to increase the number of prescriptions for chronically used medications dispensed in 90-day supplies. This strategy of workload management has been successful in recent years. In fiscal year 2003, VA dispensed 108 million prescriptions, which equates to 200 million 30-day equivalent prescriptions. This strategy allowed VA to fill an additional 92 million prescriptions than would otherwise have been the case.

VA is planning increases to CMOP capacity through replacement of existing facilities. The CMOP-Dallas facility replacement will soon begin. This newest generation automated dispensing system will increase CMOP Dallas capacity by a projected 10 million Rx/year over the current 7 million Rx/year.

The approved replacements of the Bedford and West Los Angeles CMOPs are underway. It is anticipated that these two replacements will increase CMOP capacity by a combined additional 20 million Rx/year. Both replacements should be operational by the end of calendar year 2005. Planning and assessment for CMOP upgrades and replacements beyond Dallas, Bedford, and West Los Angeles are ongoing. As future needs are identified, proposals will be made for review and consideration.

Question 4. There are concerns that the data used in the CARES analysis ignore current military realities and do not plan for the possibility of future wars. Do you believe the data accurately assess the needs of tomorrow's veterans? Can such data be developed?

Response. The CARES forecasting model uses DoD-supplied forecasts of military discharges over the 20-year forecasting period. We expect that as 000 strategic projections of military realities change, the forecasts of future discharges will change as well. We will incorporate any such changes into our future strategic planning initiatives to assess any needed modifications to the care we must provide.

As of May 19, 2004, over 21,000 veterans of Operation Iraqi Freedom and over 4,306 veterans of Operation Enduring Freedom have received health care from VA for a wide variety of health problems. Thus far, their health problems have been similar to those found in other young military populations seeking health care.

Question 5. The CARES process has not assessed VA's abilities to provide—or veterans' needs for—long-term care and psychiatric care. Why was this decision made? Who made it? Does VA plan to conduct a "CARES-like" analysis of long-term care and psychiatric care issues? If so, when can we expect such a process to take place?

Response. The DNCP does contain forecasts of acute inpatient psychiatry and outpatient psychiatry. The outpatient psychiatry forecasts were problematic and as a result they were divided into markets that showed growth and markets that showed declines in the demand forecasts. The forecasts for growth markets were included and the forecasts in markets that showed declines were "flat lined" or held at current capacity until the forecasts could be improved. That improvement is almost completed.

Long-term psychiatry and domiciliary bed forecasts were not adequately addressed in the models and were held constant until the models could be improved. The improvement of these models is almost completed. The long-term care planning model used by VA until the CARES process was determined to be inadequate for strategic planning in CARES. There was no assessment of the impact of the healthier future elderly population, female veterans, the substitution of Assisted Living or home care. Furthermore, the model did not include the latest survey data that reflect changes in the overall delivery of long term care in the US health care system.

Recognizing the importance of critical renovations, 38 nursing home projects were included in the DNCP, pending finalization of a long term care policy and incorporation into the strategic planning model. Once these data are finalized, VA will develop a revised long-term care policy.

Question 6. Many of your CARES recommendations would involve the use of VA's authority to lease out space, land, or buildings to private companies and then use the revenue to provide care to veterans. Inasmuch as you have yet to analyze the VA's needs for long-term care space or psychiatric care facilities, do you believe it is wise to begin leasing out buildings or property before that analysis is complete?

Response. Although The CARES Commission report recommends that no expansion or replacement of facilities occur while the plan for long-term care is being developed, it does acknowledge that VA should proceed with VA "renovations. . .to improve safety and maintenance of the facilities infrastructure and to modernize patient areas." We agree with the Commission that safety and maintenance of infrastructure is a paramount consideration, and we will take necessary action to ensure patient safety.

We believe that using VA's enhanced use lease authority involves similar considerations. Pending completion of our analysis for long-term care and psychiatric care

needs, we must continue to consider on a case-by-case basis opportunities to lease out buildings and property and take advantage of those opportunities where we believe they will immediately benefit delivery care to our patients.

The forecasts of long-term care space needs will be completed prior to the implementation phase of the CARES process, which will include development of plans for leasing land and buildings. In addition, while the enhanced use leasing process was recently streamlined by Public Law 108–170, it allows adequate time to ensure that any plans to use vacant space reflect needed capacity for long term care.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN NIGHTHORSE CAMPBELL
TO THE DEPARTMENT OF VETERANS AFFAIRS

Question 1. I understand that you are working out solutions for VISN's that did not receive favorable recommendations. Can you tell me if this will negatively affect those VISN's who have received positive recommendations? When do you expect the final recommendations to be approved?

Response. The Secretary published his CARES decision on May 7, 2004. The review process took into consideration all aspects of the Commission's recommendations to ensure that the CARES Plan approved by the Secretary treats all VISNs equitably, in accordance with national policy decisions.

Question 2. I notice that the CARES Commission recommends that before any action is taken on expanding or renovating long-term care facilities, the VA should develop a long-term care strategic plan, including the long-term care of our mentally ill veterans. When do you think this plan will be developed?

Response. The Long-term Care Model will be incorporated into the next strategic plan. Updates for the 5-year capital plan will be regularly completed. It will include a plan for the long-term psychiatric care. The long-term care planning that will be developed through the mental health strategic planning process will be carried out collaboratively between VA's Mental Health and Geriatrics and Extended Care staff to ensure that the comprehensive (psychiatric and medical) care needs of older veterans are met.

The CARES Commission report does acknowledge that VA should proceed with VA "renovations. . .to improve safety and maintenance of the facilities infrastructure and to modernize patient areas." However it recommends that no expansion or replacement of these facilities occur while the plan for long-term care (Nursing Homes, Domiciliary care, and long-term psychiatric care) is being developed.

Chairman SPECTER. Thank you very much, Chairman Alvarez.

We have been joined by the distinguished Ranking Member, Senator Graham.

**STATEMENT OF HON. BOB GRAHAM,
U.S. SENATOR FROM FLORIDA**

Senator GRAHAM. Thank you very much, Mr. Chairman. I would like to ask unanimous consent to submit for the record an opening statement. In deference to the members of the commission who are here and our desire to hear their evaluation of the CARES program, I will defer presenting it.

Chairman SPECTER. Without objection, your statement will be made a part of the record in full.

[The prepared statement of Senator Graham follows:]

PREPARED STATEMENT OF HON. BOB GRAHAM, U.S. SENATOR FROM FLORIDA

At the outset, I would like to extend my thanks to the Commissioners and staff who have worked tirelessly to comment on plans for the VA health care system in the future. The CARES Commission Members have held ten public meetings and 38 public hearings, visited an astonishing 81 facilities, and received more than 212,000 public comments. Mr. Alvarez, you and your Commissioners truly had a difficult job—made more difficult, in my opinion, by a flawed VA plan.

The VA's Draft National Plan—essentially vindicated by the Commission—does hold much promise for my state, where new and improved health care facilities are greatly needed. The Commission's report to the Secretary includes a proposal to build a new VA hospital in Orlando, which CARES has identified as "having the

largest workload gap and greatest infrastructure need of any single market in the country.”

The Plan also calls for the construction of new bed towers at the Gainesville and Tampa VA facilities; significant renovations at Bay Pines; a new inpatient venture with the Department of Defense in Jacksonville; and a new satellite outpatient clinic and expanding opportunities for hospital contracts in the Ft. Myers area. One area which may require additional attention is the Pensacola region. Documentation included in the Draft National Plan refers to a new “Eastern Southern Hospital”, but nothing in the CARES recommendations provides details. The Pensacola area obviously lacks sufficient inpatient capability. This clearly needs our further review.

And while I am very glad that our State will get these much-needed improvements, I remain concerned about the effects of the CARES process on the rest of the nation. The Commission’s report refines the Administration’s work—deviating from their recommendations in 12 cases and concurring in 16 cases—for a total of 20 major mission changes, including complete closures. This could have a significant impact on the availability of health care to our nation’s veterans.

CARES began with an amazing amount of attention paid to the comments of stakeholders. Unfortunately, the process took a wrong turn along the way. Halfway into the process, two dozen facilities were told to go back to the drawing board and present new plans for closures and reductions. The requests for these revisions came through last-minute phone calls and internal mandates. I trust that Commissioners were aware of this back-door manipulation and adjusted their analysis accordingly.

The Administration’s Draft National Plan also deliberately excluded the potential for needed long-term care and outpatient mental health treatment. Despite VA’s historical role in caring for these special populations, VA has chosen to ignore demand for these two services. This makes no sense whatsoever. Any plan of the proposed scope of what the Commission is looking at must address these elements. While VA has described the draft plan as “being neutral” on long-term care and mental health, it is hardly the case. Thousands of long-term care and inpatient psychiatric beds may likely be closed—a result that cannot be characterized as neutral. I know that Commissioners were made aware of this flaw but did not, and could not, revamp the entire plan in order to fix it.

Finally, if sufficient resources are not dedicated to CARES enhancements, the entire process will ultimately be interpreted as just one more blow to veterans. Indeed, the cost of CARES improvements will total more than \$4.6 billion. With a mere \$180 million included in the President’s budget for these types of projects, we certainly have a long way to go to deliver upon the promise of CARES—in Florida and across the country.

Thank you.

Chairman SPECTER. Senator Hutchison, would you care to make an opening statement?

**OPENING STATEMENT OF HON. KAY BAILEY HUTCHISON,
U.S. SENATOR FROM TEXAS**

Senator HUTCHISON. Thank you, Mr. Chairman. I do have an opening statement. This is a very important topic, but since we do have Members here and I know we are voting right now, I will incorporate my opening statement into my questions. I do hope we will have enough time in our question sessions to be able to do that so that we can hear from our witnesses.

Chairman SPECTER. Senator Hutchison, we will see to it that you have sufficient time.

Senator HUTCHISON. Thank you.

Chairman SPECTER. Our next witness is the Honorable Robert Roswell. Dr. Roswell is the Under Secretary of Health for the Department of Veterans Affairs. Prior to his nomination, Dr. Roswell served as the head of VA’s health care network for Florida and Puerto Rico. He is a 1975 graduate of the University of Oklahoma School of Medicine. He served on active duty in the Army from 1978 through 1980 and is currently a Colonel in the Army Reserve Medical Corps.

Thank you for joining us, Dr. Roswell, and we look forward to your testimony.

STATEMENT OF HON. ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. ROSWELL. Thank you, Mr. Chairman and Senator Graham. It is a pleasure to be here before the Committee today.

On February 12 of this year, the commission presented its final report to the Secretary, with findings and recommendations. VA is currently reviewing the CARES Commission report. However, we must await the Secretary's final decision on this comprehensive report later this month. Thus, I would be unable to give our responses to the commission's recommendations to you today.

Since the preparation, though, of the draft National CARES Plan, I would like to share with you that we have continued our planning efforts. Our initial forecast models did not fully address the future long-term care needs of veterans. As a result, the CARES planning model ensured that long-term care capacity was maintained at its current level.

Since release of the draft National CARES Plan, we have been working to develop a long-term care demand model based on more recent and more complete information, including current national long-term care survey criteria, disability data and reliance factors. Also, we are viewing VHA long-term care policy in key areas to assure that policy and capital planning will be coordinated, and that policy supports the vision of providing veterans with the highest-quality long-term care in the most supportive, least restrictive environment that is compatible with the veteran's medical condition.

With regard to mental health programs, VHA is developing a comprehensive mental health strategic plan to transform its mental health programs consistent with the recommendations contained in the President's New Freedom Commission Report on Mental Health. This plan will recommend fundamental changes in the structure, policy and culture of our mental health care delivery system.

As a part of the plan, VHA is creating a vision for delivery of care to veterans with mental illness and substance abuse within a system that places equal importance and emphasis on mental and physical health and is an integrated, veteran-centered program and is based on a model of recovery.

I have instructed VHA planners to assure that programs in our domiciliary structures are focused on residential rehabilitation and that each patient have an individual clinical treatment plan. As each program, such as our mental health, substance abuse and long-term services, defines its discrete capacity for residential rehabilitation, VHA will have a more complete picture of the total capacity requirement for our domiciliaries.

Mr. Chairman, we are also reviewing the critical access hospital concept that was presented in the draft National CARES Plan and are developing a definition of what we now call veterans rural access hospitals and how such facilities should function in our health care delivery system. These facilities will be important in providing

access to health care in rural markets where access to VA and/or community care is limited.

Mr. Chairman, should the Secretary approve the final CARES plan, implementation will take place over a period of many years. The complexity of realigning clinical services and campuses necessitates careful planning in order to assure a seamless transition in services. In no case will we discontinue services without having alternative services and sites of care available and operational.

Throughout the implementation process, we will keep you and other Members of Congress informed and involved. And just as important, we will keep our patients and their families informed and involved in the process.

This concludes my opening remarks. I would be happy to try to answer any questions you or Members of the Committee may have. [The prepared statement of Dr. Roswell follows:]

PREPARED STATEMENT OF HON. ROBERT H. ROSWELL, M.D., UNDER SECRETARY
FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee: I am pleased to appear before the Committee to discuss the Department's ongoing efforts with regard to CARES.

The CARES process has involved one of the most comprehensive evaluations of the VA health care system ever conducted. It is a data-driven planning process designed to project future demand for health care services in 2012 and 2022, compare them against the current supply, and identify the capital requirements and the asset realignments VA needs to improve access, quality, and the cost effectiveness of the VA health care system.

Last September, Secretary Principi and I appeared before this Committee to discuss both the CARES process and the VHA draft National CARES Plan. At that time, the CARES Commission, under the superb leadership of Everett Alvarez and John Vogel, was nearing the end of its site visits and public hearings and was preparing to begin the daunting task of writing its report. On February 12 of this year, the Commission presented its final report to the Secretary, with findings and recommendations.

VA is currently reviewing the CARES Commission Report. However, we must await the Secretary's final decision on this comprehensive report later this month. Thus, I will be unable to give you our responses to the Commission's recommendations today.

Mr. Chairman, we know that many stakeholders have expressed concerns about how VA intends to address the provision of long-term care and mental health services, and the Commission raised questions about our proposal for "critical access hospitals." I would like to say just a few words on these issues.

Our initial forecasting models did not adequately address the future long-term care needs of veterans. As a result, the CARES planning model ensured that current long-term care capacity was maintained. Since release of the draft National CARES Plan we have been working to develop a long term care demand model based on more recent and more complete information, including current national long-term care survey criteria, disability data and reliance factors. Also, we are reviewing VHA long term care policy in key areas to assure that policy and capital planning will be in synch and that policy supports the vision of providing veterans with the highest quality long term care in the most supportive, least restrictive environment that is compatible with the veteran's medical condition and personal circumstances.

In regards to Mental Health Programs, VHA is developing a comprehensive mental health strategic plan to transform its mental health programs consistent with the recommendations contained the President's New Freedom Commission Report on Mental Health. This plan will recommend fundamental changes in the structure, policy, and culture of our mental health care delivery system. As part of the plan, VHA is creating a vision for delivery of care to veterans with mental illness and substance abuse within a system that places equal importance and emphasis on mental health and physical health, is integrated, veteran-centered, and based on recovery.

Developing a mental health demand model that accurately projects the full range of mental health services needed by veterans has been challenging. A revised model that is more detailed and improves on past efforts is currently being developed. The

resulting options for mental health care will ensure that VHA maintains a robust system of coordinated, integrated, “state-of-the-art” care for veterans with mental health care needs.

We have conducted several studies of domiciliary programs over the past year. These studies highlighted—

- The need for effective coordination with non-VA programs and services to assure that integration is achieved across a continuum of care that is directed to meet the specific needs of individual veterans.
- That patients need to move to the least restrictive environment consistent with their needs.
- And that data based population planning is needed to bring about some uniformity of access to this therapeutic residential care continuum including consideration of available State Home Domiciliary programs as well as innovative VA/community partnerships providing Domiciliary services.

Accordingly, I have instructed planners to assure that programs in domiciliary structures are focused on residential rehabilitation and that each patient have a clinical treatment plan. As each program (e.g. mental health, substance abuse, long term care) defines its discrete capacity for residential rehabilitation, VHA will have a more complete picture of the total capacity requirement for domiciliaries.

Mr. Chairman, we are also reviewing the “critical access hospital” concept that was presented in the draft national plan and are developing a definition of what we now call “rural access hospitals” and how such facilities should function in our health care delivery system.

We believe that these facilities may be important in providing access to health care in certain rural markets where access to VA and/or community care is limited. Such facilities would need to be part of a network of health care that provides an established referral system for tertiary or other specialized care not available at the rural facility. The facility should also be part of a system of primary health care (such as a network of CBOCs). Such facilities would also need to be a critical component of providing access to timely, appropriate and cost-effective health care for the veteran population served.

Mr. Chairman, should the Secretary approve the final CARES Plan, implementation will take place over a period of many years. It will be a multifaceted process, depending upon whether implementation of specific initiatives requires additional capital, recurring funding, primarily policy changes, or realignments. In particular, the complexity of realigning clinical services and campuses necessitates careful planning in order to ensure a seamless transition in services. In no case will we discontinue services without having alternative sites of care available and operational. And throughout the implementation process we will keep you and other Members of Congress informed and involved and, just as important, we will keep our patients and their families informed and involved.

This concludes my statement. I will now be happy to answer any questions that you or other Members of the Committee might have.

Chairman SPECTER. Thank you very much, Dr. Roswell. I am glad to hear your assurances that long-term care will be maintained at the current level and there will be no discontinuance of services.

Chairman ALVAREZ, with respect to what is proposed to happen in Pittsburgh, there is a \$100 million construction project at Pittsburgh University Drive and Pittsburgh Heinz, to be followed by the closing of Pittsburgh Highland Drive. Are you in a position to assure this Committee and the veterans who receive their care in Pittsburgh that the substitution will result in at least equal, if not better, care for the Pittsburgh veterans?

Mr. ALVAREZ. Mr. Chairman, the commission looked at that very carefully and with regard to the \$100 million, one of the recommendations was that they take another look at the cost of that because the numbers we had, we felt, were soft. We feel that it may be a little more than that, but the reality is that those numbers will be solidified.

With regard to transferring to the university level, we stated in our recommendation that no transfer be done until the facility at the university——

Chairman SPECTER. Chairman Alvarez, I don't want to interrupt you, but we have a very limited amount of time. Let me ask you to supplement what you have said in writing with a specification as to what services will be lost by the closing and what services will be gained.

Mr. ALVAREZ. Will do, sir.

Chairman SPECTER. Moving on to other facilities, there is a concern that when you close inpatient beds that there will be an inevitable consequence that other Pennsylvania institutions such as Altoona, Butler and Erie—that there will be a closure of emergency room and intensive care unit capabilities which cannot be maintained without the inpatient beds.

Taking a look first at the ripple effect on Erie, where there are about 800,000 applications per year for treatment in the emergency room, the Erie VA has an intake of about 1,000 of those individuals, and only 71 need to be referred to the local community hospital for services not offered at the VA.

If the VA loses its inpatient beds and then the emergency room private referrals will rise from the 71, which we have had the experience on, to 1,000, won't that result, if my underlying facts are correct, in a substantial increase in cost to the Veterans Administration?

Mr. ALVAREZ. I think Dr. Roswell can probably address that one better, but our concern was that they take a good look at that as the transfer is being planned, because what we basically specified was that we recommend that they do it carefully, if they do it, so that there is no loss of service there.

Chairman SPECTER. Well, I am glad to hear there will be no loss of services, but would you please supplement what you have said now? We are going to have a hearing in Erie in March 26. I will be there, the Committee will be there, and I would like to know the specifics as to how the services will be given and what the cost will be to the Veterans Administration and whether you really will be saving money.

There have been efforts all along the VA system, and I will be detailing those as to these three facilities, to increase efficiencies. You talk about population shifts and efficiencies, and I agree with you that those are the standards.

But if you take a look at Erie, in 1997 the Erie VA had 26 inpatient beds and 9 surgical beds to provide care for 11,400 veterans. Those medical and surgical bed units have been merged into a single 26-bed unit and now serve some 18,500 veterans.

With those kinds of efficiencies, and taking into account the population shift, Chairman Alvarez, doesn't it make sense to keep open the inpatient beds which are now remaining and have been consolidated at Erie?

That will be final question because I intend to observe the time limits, as we all will, but you may answer.

Mr. ALVAREZ. Thank you, sir. I would answer any specifics you would care for us to submit.

With regard to the number of visits, most of those, 94 percent of those, are outpatient, sir. And the number of inpatient beds that we have is one that is a declining number over the last several years. That was one of the things that we were concerned about when we looked at the statistics.

Chairman SPECTER. Well, my time has expired. We will come back. I am going to yield now to Senator Graham and when I yield to him I am going to go to vote. Senator Murray has already returned, and when Senator Graham finishes his questioning, Senator Murray, we will turn to you so that we can continue apace even though we will be moving in and out on the votes.

Senator GRAHAM. Mr. Chairman, we are on the second bell on this vote. If it is acceptable, I would like to defer to Senator Murray and I will vote and then ask my questions at a later time.

Chairman SPECTER. I think that is a splendid idea. That way, you run no risk of missing the vote.

Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman. Thank you, Senator Graham. Thank you again to the panel. I appreciate you being here.

As you know, as I stated, I have written to Secretary Principi several times about my concerns on this. Dr. Roswell, I have outlined those concerns actually several times in writing to both you and Secretary Principi since the time my VISN director was directed to close three of the five VA medical centers that were in Washington State.

The CARES report recommends a significant mission change at Walla Walla VA Medical Center in my home State of Washington. However, the current law which I have a copy of here stipulates that no mission change shall occur at this facility. In fact, the current law says the mission of the Veterans Administration Medical Center at Walla Walla, Washington, shall not be changed from that in existence on January 1, 1987. Yet, your CARES Commission recommends that it be changed.

How do you plan on reconciling that situation?

Dr. ROSWELL. Senator Murray, I am no legal expert, but we did refer that law to our general counsel for interpretation and I believe the Department's general counsel's interpretation was that because that law was a part of the appropriation language—it may not have been appropriation language; I may be mistaken with that.

As I recall, the general counsel opinion was that that law pertained only to the mission during the term of the authorization and/or appropriation bill. I guess it was——

Senator MURRAY. It was 1987.

Dr. ROSWELL. It was 1987. I actually recall that law at the time of its passage, but the general counsel interpretation was that it would only pertain to the fiscal year in which it was enacted. Again, that is a general counsel opinion. That is not my opinion.

Senator MURRAY. Well, we will continue that discussion with you.

The recommendation for the Walla Walla center is to maintain outpatient services by moving outpatient care off of the Walla

Walla VA Medical Center campus. Can you explain to us what that means? Are we going to build a new facility for Walla Walla?

Dr. ROSWELL. The Walla Walla campus, as you know, is a fairly large campus. We would not be expected to maintain the entirety of the campus to provide just outpatient care. So my understanding would be that we would evaluate where best to locate outpatient services. That could be on a portion of the existing campus or it might be better situated in a new location not on the current campus.

Senator MURRAY. Well, there is no money in your budget to do that, so how does that happen?

Dr. ROSWELL. There is money in our budget to the extent that major construction money is identified for CARES-related construction needs.

Senator MURRAY. Well, yes. Actually, we do know that you shift \$400 million from the veterans' health care into the construction account. I am assuming that is what you are talking about.

Dr. ROSWELL. In fiscal year 2004, yes, ma'am.

Senator MURRAY. Well, I am deeply concerned about that because shifting that health care to an initiative that is going to close the very facilities that serve our veterans today really, to me, is unconscionable. I don't see how our veterans can feel secure when the promise to provide the health care that they have earned is preceded by a budget request from you that would not only under fund the health care account by moving that \$400 million, but it also robs that account to pay for CARES projects.

I mean, how do you reconcile this? You have to understand how our veterans out there are feeling. You are recommending closing their facilities. You are saying something is going to happen in the future, but there is no money in the budget to do it, and we are reducing the health care to build some facilities that we don't even know what they are.

Dr. ROSWELL. Let me back up. The expectation would be that leaving the current campus would be if there is an enhanced use leasing opportunity that would generate sufficient revenues to cover the cost of relocating the facility.

Senator MURRAY. An enhanced lease use facility that you are looking for somewhere else? I mean, have you ever been to Walla, Walla? There aren't very many facilities there.

Dr. ROSWELL. I understand, and it is entirely possible that—again, I don't believe that there is any foregone conclusion, that the outpatient services would be moved off the current campus. It is simply an option that would be explored.

Our goal would be, if this CARES recommendation were accepted by the Secretary, to provide the highest-quality environment of care for continued outpatient services either on the current campus or, if it was more conducive to delivering outpatient services, to a location off the current campus. But, again, that would be something that would have to be determined.

Senator MURRAY. Well, I remain deeply concerned because I know your office makes a recommendation by the end of this month. Congress has 60 days to review, whatever that means; at this point, I am not sure. Meanwhile, we won't have identified for those veterans where they are going to receive the care.

I just think we need from your office specific budgets and time lines and specific places where these veterans are going to receive their care before we end up at the end of our 60-day time line and we are still sitting here asking you the same questions we have been asking for the last several months.

Dr. ROSWELL. Let me assure you that the Department will not take any action to close the current campus until we have fully identified where outpatient services would be provided, how they will be provided, and we would not close the current facility until——

Senator MURRAY. But if you accept the CARES recommendation, it states specifically that that is going to happen. So you say on one hand the CARES Commission is accepted; that is what we are going to do. But then you say we are not going to do that until we have something. I am as confused as my veterans.

Dr. ROSWELL. If the recommendation is accepted, as I said in my opening statement——

Senator MURRAY. By your office.

Dr. ROSWELL. By Secretary Principi.

Senator MURRAY. Right.

Dr. ROSWELL. But, yes, it would be implemented over a period of years. In no case would we close or implement any of the recommendations that resulted in closure of a facility until such time ask the facilities intended to replace that are in place.

Senator MURRAY. And by “facilities” do you mean some new facilities in Walla Walla that will be built that we haven’t budgeted for?

Dr. ROSWELL. We would either maintain an outpatient facility on the current campus or create a new one somewhere in the Walla Walla area to provide complete continuity of outpatient services. There will not be an interruption of outpatient care for veterans served by the Walla Walla facility.

Senator MURRAY. And this is based on that we just trust this is going to happen, because I don’t see it in the budget?

Dr. ROSWELL. I understand your concern. Let me point out that there is already money in the 2004 appropriation set aside for use of CARES at the Secretary’s discretion. There would be up to \$400 million that could be reprogrammed. In addition to that, there is additional money requested in the 2005 budget that is now being considered before this Congress. The Secretary has made a firm commitment in addressing the CARES Plan that there would not be an interruption of services.

Senator MURRAY. For outpatient. What about inpatient?

Dr. ROSWELL. The commitment expressed by the Secretary is that there won’t be interruption of any services.

Senator MURRAY. Inpatient or outpatient?

Dr. ROSWELL. That may mean that outpatient would shift to a contract delivery process, but we would always have a mechanism in place to provide that care on a contractual basis before we closed any facilities.

Senator MURRAY. Again, let me just point out to you, Dr. Roswell—and I know you are working within confines and you are doing the best you can, but there are no other facilities in Walla Walla to contract out to. And that is, I think, one of the deep concerns many of us have about the CARES recommendations.

I have taken my time. Thank you, Mr. Chairman.

Senator GRAHAM. Thank you, Senator Murray.

Senator HUTCHISON. [Presiding] Mr. Chairman, I think the gavel is mine, but did you wish to go next? I would be happy to call on you.

Senator GRAHAM. Thank you very much, Madam Chairman.

I would like to go back to this issue of long-term care, because we know that it is going to be an area of increasing demand. I think also we'll see a demand for greater diversification in the ways in which that care is provided, including long-term care within the communities to various forms of institutional care.

Where is the CARES program on that issue, and what are your recommendations as to how the VA should deal with the demand for long-term care?

Mr. ALVAREZ. For the first part of that question, sir, I think Dr. Roswell could probably answer that and I will defer to him on the first part.

Dr. ROSWELL. Obviously, a long-term care projection model wasn't included in the draft National CARES Plan submitted to the commission because we were not comfortable with the data. We have been working diligently with our actuaries to refine a projection model. We believe we are very close to a model that would project the needs for long-term care.

That will require some policy issues that the Secretary will want to evaluate before making final determinations, but that process would then be incorporated into a continuous strategic planning process that will continually address and adjust our programs to meet the long-term care needs of the Nation's veterans.

Mr. ALVAREZ. Sir, Dr. McCormick can address the latter part of your question with regard to our recommendation on that.

Mr. MCCORMICK. Yes. In our cross-cutting issues, we were concerned that even though the long-term care model wasn't done, there were a number of specific items that actually addressed long-term care at specific sites.

Two things. First of all, in our cross-cutting issues we made a very strong statement that we believed that no action should be taken on altering or changing current long-term care until a strategic plan is put together, and that that plan needed to consider the broad needs of long-term care for the highest-priority veterans, including those with mental disorders who will need long-term care as well.

When we then came to specific issues where there was a recommendation about a specific nursing home, we made a judgment but always put a caveat in that it was subject to being consistent with the eventual model that would be run that would say what kind of beds we need to serve what veterans in what location.

Senator GRAHAM. Well, I remember this Committee and the full Congress adopted a directive to the VA relative to long-term care, I believe, in 1999. It sounds as if the information that you are now suggesting needs to be developed is the kind of information which the 1999 directive precipitated.

What has happened to that 1999 legislation and to what degree is it going to be involved in your development of the strategic plan?

Mr. MCCORMICK. Again, we emphasized that we felt that the Department needed to follow the millennium bill guidelines, which had to do with priorities again to have the right kind of nursing homes especially for the highest-priority patients. We also acknowledged the nursing home floor that was put into that.

Again, our position was that the real issue wasn't even how many beds we had overall in the system, but what kinds of beds, where and whether, to address the needs of each specific type of patient who would need long-term care into the future.

Senator GRAHAM. Could you give the Committee a memorandum of what has happened since the Millennium Health Care Act—where that Act stands and how it is going to fit into your planning for long-term care services and facilities?

Mr. MCCORMICK. I guess that would be Dr. Roswell's—

Dr. ROSWELL. Yes, sir. That law requires that the VA maintain its 1998 long-term care patient census of 13,391 patients. We have implemented management guidance, including a pro-rated quota, of that national-mandated floor on inpatient levels to each of the 21 VISN directors.

Despite those management incentives, the demand for care is such that we are not currently at the 13,391 statutory requirement. We are closer to about 12,000 patients right now, despite our efforts to maintain that patient census within our facilities.

I would note that we have significantly increased, during this time period, the State veteran home nursing beds available. In your own State of Florida, for example, a number of State veterans homes have opened, creating other options for veterans at multiple locations.

We also have significantly increased, almost tripled, the non-institutional care programs that serve veterans in the least restrictive setting. So we are expanding a full continuum of services that would be reflected in the long-term care strategic planning model that has been referenced here.

Senator GRAHAM. Mr. Chairman, my time is up. I would like to indicate that I am going to be asking a question relative to the status of a new hospital that the Administration had indicated it supported. I am speaking about a hospital in Pensacola, Florida, which has already been named the Eastern Southern Hospital. There doesn't appear to be any provision in the CARES report or in the Commission's commentary relative to that hospital, and I would like to get an understanding of why there has not been such a provision made.

Chairman SPECTER. Thank you, Senator Graham.

Senator HUTCHISON.

Senator HUTCHISON. Thank you, Mr. Chairman.

Mr. Alvarez, early in this process our veterans organizations and local community leaders worked with their respective service network regional directors to develop plans to optimize their facilities, but the report bears almost no resemblance to the original recommendations made by the service network directors in the field.

One example: the veterans integrated service network market plan recommended establishing Waco as a regional psychiatric resource. The plan spoke of an enhanced mission for Waco by ex-

panding the geographic service area and working to designate the Waco VA hospital as a Psychiatric Center of Excellence.

When you consider that the Veterans Administration has spent more than \$80 million over the last 10 to 15 years building state-of-the-art psychiatric care facilities in Waco training technicians and nurses in this specialized field—and when we visited this facility with Secretary Principi, we learned that there are interns and residencies which could also be enhanced from the medical school at Texas A&M, very close by—the original recommendation to consolidate psychiatric services in Waco seemed to be a good use of taxpayer funds. However, the report completely reversed that and suggested that most of the services from Waco be moved to other places.

In addition to that, your early reports estimated that it would cost about \$16 million to move these services. Now, we have just spent \$80 million over the decade renovating and upgrading the psychiatric facilities at Waco. Now, we are talking about \$16 million to move it, and Representative Edwards was told by someone in the VA that the moving cost was more likely \$42 million.

So could you expand on how you came to the conclusion that moving the major parts of the psychiatric services, inpatient, from Waco would be prudent for the taxpayers and better service for the veterans?

Mr. ALVAREZ. Thank you, Senator. Let me just State that the market plan that you referred to which called for upgrading of the programs at Waco was not in the draft national plan that we received. The plan that we received was the plan that transferred inpatient acute psychiatric beds from Waco to Temple and to the Austin area.

Ninety-four percent of the current workload at Waco is outpatient care, and that is to remain there at Waco, whether it is a portion of the campus or in the city itself. So the other plans that you have mentioned really did not surface in the draft national plan and it was not presented to us.

As far as a \$15 million cost to transfer that, what caught our attention was that we were told at the hearing by the VISN director and staff that currently he was having to redirect about \$15 million from other facilities in his network to support the operation at Waco because of the large overhead of that campus. So that was one thing.

When we took a look at the cost/benefit analysis that was proposed for Waco that was submitted at the end of October—and we have questions about this—the life cycle cost savings over 20 years would range from \$200 million to \$800 million. Well, the commission did not believe the \$800 million, and probably the \$200 million is closer to it. But that was one of the factors that we said take another look at that and see what the more realistic numbers were. So taking everything into consideration, our recommendation then basically went with the plan.

We also put some caveats on this. You have some hard-to-place inpatients in the nursing home that we said let's take a good look at those because that kind of care is usually not provided in the community. Dr. McCormick can probably address that better than I can, but the key was that that large overhead that was causing

him to redirect money from other facilities to keep that operation going was a major factor.

Senator HUTCHISON. You are talking about the inpatient psychiatric?

Mr. ALVAREZ. No, the cost of the campus itself.

Senator HUTCHISON. The campus itself.

Mr. ALVAREZ. He would prefer to move, even if he has to stay on that campus, to another location there if he could get the money to build it, a multi-specialty outpatient clinic either built or leased in the community. That would save him a lot of money and provide up-to-date, modern care for the people of that community.

Senator HUTCHISON. Well, let me just say, first of all, that the inpatient—you were saying that 80—what percentage did you say is outpatient care?

Mr. ALVAREZ. Ninety-four percent of the workload.

Senator HUTCHISON. Ninety-four percent. So you are saying that only 6 percent of the workload is the inpatient psychiatric?

Mr. ALVAREZ. Yes, ma'am.

Senator HUTCHISON. That just defies what we saw there in the inpatient facilities. I am sure you are not not telling the truth, but somehow we are talking apples and oranges because we saw inpatient facilities with 60-patient capacity that were pretty well full.

Mr. ALVAREZ. You have 110 beds there, inpatient.

Senator HUTCHISON. Yes, so it is not adding up.

Mr. ALVAREZ. Would you like to expand?

Mr. MCCORMICK. To clarify, the 94-percent figure is that 94 percent of the patients who get care at Waco receive only outpatient care, which is not unusual. There is a substantial inpatient workload there.

Let me just say one thing, if I could, that you will find in the report that we tried to be consistent. One of the advantages of the proposal for Waco was to move some of the acute beds to Austin. There is a very large, as you know, I am sure, Senator, outpatient clinic in Austin that treats about 16,000 veterans a year, about 3,000 with mental disorders.

Right now, when one of those patients needs acute inpatient psychiatry, which usually means he is either suicidal or seriously mentally ill, he most often ends up having to go all the way up to Waco. One of the principles that we used was that in a city the size of Austin there ought to be access to acute inpatient psychiatric care. So one of the strengths of their proposal was to move some of the beds closer to where the veterans lived in Austin so that their families can be engaged in treatment.

The second strength of that proposal was to move the remaining long-term and acute beds to Temple, which would put them more centrally in the market, but also right on the same campus with the medical beds. And as these patients age, there is a clinical advantage to having acute psychiatric and acute medical services in very close proximity.

It was really the access issue, at least from my perspective, which caused us to approve of that plan because we felt it was a strength and improved access and quality of care for veterans in that central Texas market by putting the services closer to where the bulk of them live.

Senator HUTCHISON. Let me just say that it seems to me that having the specialty doctors and nurses, the trained people, is going to be more cost-efficient if it is in fewer places. If you are going to be inpatient, the difference between traveling to Waco or Temple would not seem to be that big a difference, where you have the investment already at Waco.

Let me just add that if the overhead cost of the campus is an issue, then what I am hoping is that with the added emphasis that the community wants to bring forward in filling the buildings, in taking responsibility for maintaining the campus—and further, in your report you recommended closing the Marlin facility and building a new multi-specialty outpatient clinic someplace in the Waco area, which would seem to be much more economically done on a campus that the VA already owns, upgrading facilities there and thereby filling the buildings and lowering the cost.

So that is where I am hoping that we can add to your body of knowledge and make the case to Secretary Principi that we still can be efficient and keep the trained workforce in place.

Chairman SPECTER. Senator Hutchison, you are now at double time, a little over 5 minutes over. I know how important the Waco hospital is to you, so I haven't interrupted you, and the witnesses may answer your question.

Senator HUTCHISON. I would love to just have them answer this, and then there will be a second round?

Chairman SPECTER. That would be a third round?

Senator HUTCHISON. Could there be a third round, then?

Chairman SPECTER. Yes.

Senator HUTCHISON. Thank you. Well, a lot happened in Texas, Mr. Chairman, so I am trying to focus on this.

Chairman SPECTER. I know how important this is to you and I haven't interrupted you. We will come back for another round.

Senator HUTCHISON. OK, if they could answer this.

Chairman SPECTER. The witnesses may respond to your question.

Mr. ALVAREZ. With regard to Marlin, Marlin is already closed, inpatient. It is outpatient, and the draft national plan calls for consolidating Marlin with a Waco outpatient somewhere in the vicinity. We also said take a look at that before you do that; because of the location where you want it, be careful how you do that.

Mr. MCCORMICK. I would just say one more thing about acute inpatient psychiatry, Senator. When you are treating 3,000 patients in a large metropolitan area like Austin on an outpatient basis, acute inpatient psychiatry is a critical part of the care.

While 50 years ago we put our psychiatric hospitals way out in the country, right now, of course, we have them very close to where the patients live because the stays are shorter, the family needs to be involved in the care. The family needs to be able to not only visit, but really take a part, and we need to rehabilitate the patients and put them back in the community.

The last thing I would use would be a case example. There are very fine mental health staff at your clinic in Austin, and they shared with me when I visited there the dilemma that we have a one hundred-percent service-connected patient with schizophrenia showing up in an agitated state. The ideal thing would be to admit him to a VA bed right there.

This is not a small city, Austin. By taking him all the way to Waco, you then separate him from his family. He may have to wait in an agitated State for an hour for an ambulance to arrive and then make the ambulance ride up there. With all due respect, that is not good care, Senator.

Mr. ALVAREZ. Finally, Senator, if I could finish up, with regard to the community, the community became very active and really worked cooperatively. Our recommendation calls for more time so that the VISN director can work with the community to see if they can come to a solution for that campus itself, see what else can be done there. So my understanding is that they are working closely with them, but we will see what develops.

Chairman SPECTER. Chairman Alvarez, coming back to the Altoona facility which I had mentioned earlier, in 1997 the Altoona VA maintained 38 inpatient beds to care for 8,900 veterans. Now, it has 28 beds, a 26-percent decrease, and provides care for more than twice as many patients, 23,000. Its average length of stay on inpatient admissions is 5.64 days, equal to or exceeding the standard of Medicare and the Pennsylvania Hospital Association.

Altoona's intensive care unit was recently renovated and is a state-of-the-art facility.

What would the justification be under these circumstances for eliminating the inpatient beds at Altoona, Mr. Chairman?

Mr. ALVAREZ. Mr. Chairman, you are correct. Currently, they have 28 operating internal medicine beds. Last year's daily census was 19 and it has been declining, and our recommendation is to watch that closely.

Now, when you talk about the number of veterans coming in, the far majority of those are outpatient and specialty programs. Again, consistent with our entire effort, we would like to see more care for those veterans coming for ambulatory care, special programs, et cetera.

Chairman SPECTER. Well, where are they going to get that special care?

Mr. ALVAREZ. Well, you are not doing any surgery now at Altoona now, but Dr. Roswell can probably be more detailed.

Chairman SPECTER. Excuse me. Where are they going to get that special care if you close the Altoona inpatient beds?

Mr. ALVAREZ. Well, the kind of care I am talking about is expansion of outpatient care, more CBOCs, bringing access to care to the community, and as Dr. McCormick indicated, to include mental health services at the CBOCs out at the community level, that kind of an emphasis.

When our commission took a look at the Altoona situation, recognizing the dynamics of the area, all we are really saying is take a good, careful look at that, and when it is reasonable it would make sense to go ahead and shut that operation down. You have 11 community JCHA-approved providers within a 60-minute radius of Altoona.

Chairman SPECTER. What will the cost of that be to the VA?

Mr. ALVAREZ. I don't have a figure on the cost at this point, but that is part of our recommendation.

Chairman SPECTER. Well, wait a minute, wait a minute.

Mr. ALVAREZ. Yes, sir.

Chairman SPECTER. Is that important that you don't have a cost figure? How can you close Altoona and send them elsewhere if you don't have a cost figure for comparison? How can you do that?

Mr. ALVAREZ. Our recommendation is to do the cost/benefit analysis, and when it is reasonable at some point, go ahead and make that move.

Chairman SPECTER. Now, wait a minute. If you are saying do a cost/benefit analysis and you haven't come to a final conclusion about the Altoona facility—

Mr. ALVAREZ. That is right.

Chairman SPECTER. You can't come to a final conclusion about Altoona unless you do a cost/benefit analysis.

Mr. ALVAREZ. That is right, sir.

Chairman SPECTER. So you are not recommending the closing of the inpatient beds in Altoona?

Mr. ALVAREZ. We are saying do that when it is reasonable at some point.

Chairman SPECTER. But you have been charged, Mr. Chairman, with making a determination as to what is reasonable. That is your job. The people in Altoona think that you want to close them down. Do they have the wrong impression, because that is what your report says?

Mr. ALVAREZ. Our report says at that point when it is reasonable to close inpatient services, to go ahead and do that.

Chairman SPECTER. Well, if you are saying when it is reasonable, then you are frankly not saying much at all.

Let me go on to—

Dr. ROSWELL. Mr. Chairman, if I may, the draft National CARES Plan felt that that reasonable point would be approximately 10 to 12 years from now, possibly 2012 or 2014.

Chairman SPECTER. Well, who knows what is going to happen between now and 10 to 12 years from now? Are you going to come back with another commission and Mr. Battaglia will be chairman by that time? Is that what you are going to do?

What value does this commission report have if you are going to come back 10 to 12 years now and if it is not going to take effect until 10 to 12 years from now? You know, I am only going to be in the Senate for 20 more years. I might not even be here.

Dr. ROSWELL. I think the sense of the report—certainly, my read of the commission's recommendation was if the inpatient census declined precipitously prior to 2012 or 2014, then we would need to reevaluate and consider closure at that time.

Chairman SPECTER. And if it doesn't decline precipitously, then you would keep it open?

Dr. ROSWELL. In my interpretation, it would not be feasible. The recommendation was to close those beds as soon as feasible. If the census is maintained at the current level or actually increases, then in my opinion, strictly in my personal opinion, it would not be feasible.

Chairman SPECTER. Dr. Roswell, you don't have a personal opinion. You are a ranking official at the VA. You speak for the VA and I like what I have heard.

Senator Rockefeller, there is another vote on, so I am going to excuse myself for a while.

Senator ROCKEFELLER. Good. I can be Chairman again?

[Laughter.]

Chairman SPECTER. Acting Chairman.

Senator ROCKEFELLER. Dr. Alvarez, let me go at this maybe a little different way. What you do is you go down and you have your principles of how it will affect access and costs and alternatives in the community and the rest of it. You had a lot of places to visit, or your people did. I mean, I don't know how you did it.

There are two ways to visit a community, it seems to me. One is that you do it the way any President does, so to speak, Republican or Democrat; in other words, what I call rope line. You go in, you see a cross-cut of veterans and you see the administrators, you talk to a couple of people and you are out of there, not because you want to be, but because you have to be.

Then there is another way, which is what I want to talk about, with the indulgence of the Chairman, which relates specifically, in fact, to the VA hospital in Beckley. I mentioned before that about 4 percent of the land is flat. In southern West Virginia, probably it is about 2 percent. Let me phrase it this way. If I were to ask what this means that people would have to go to Richmond or Salem, your answer might be yes, and then your presumption might be, well, they could do that.

Southern West Virginia is one of the poorest places in the country. The county right next to it, Raleigh County, is one of the four poorest counties in the country. Every time I am in West Virginia, I always try to meet with the families of Iraq reserve, regular and guard. The idea is that what I am trying to do is get a statewide organization so that they can develop things like we have to pay for our meals even when we come home and a lot of different factors, or just timing.

I was in Mercer County, which is actually south of Richmond, but which is in West Virginia, and I was suggesting to them, why don't you get together with the people in Raleigh County and form a unit. I am trying to do this on a statewide basis. They said to me, well, we can't go to Raleigh County; it is much too far to drive.

Now, I am not judging them, but that was their view. I can either say I can change their behavior by pointing out that it is an hour-and-three-quarters up the interstate, something like that, once you get to the interstate, or I can accept the fact that if that is their mindset—and remember how they came; they were the people who basically left Virginia because Virginia didn't want us, and they were the ones who went into the southern mountains, which is where they are with their long rifles, and sort of said "don't tread on me." They have had that mindset ever since, and they did toward me when I came to West Virginia from some strange State in the northern part of this Northeast. They were very suspicious for a very long time. They don't change their ways as fast as other people do who are in a much more mobile psychological and economic economy. So the fact is they probably won't go to other places.

You have a copy of the West Virginia Hospital Association. I went and I talked with those hospital directors, including the ones in Beckley, where they have the beds—see, it is deceptive—but they don't have the doctors or the nurses to staff the beds. So what

appears to be a possible turns out to be an impossible because of the nature of southern West Virginia, where it is harder to live; it is just harder to live, lots of things.

It turns out, in fact, that if you do go to another place, it does cost more. And what does it save the Veterans Administration? \$3.4 million, if you stay at Beckley. So you can say, well, that is not much of a case, Jay; we have got billions of dollars. I would say, no, it is a case because it is a cost/benefit thing.

So you combine the unwillingness or the inability—it is not unwillingness; it is sort of that people don't travel; they won't travel—with a lack of transportation to the hospital infrastructure, in spite of the work that the DAV and VSOs and the VA does, and they don't have that sufficiently. And you add on the vet centers and that still doesn't do it because you are talking about more serious work, and the 550 jobs at the hospital.

I just put that before you that when you are looking at you are looking at your five principles, sometimes what sticks out at you is not the condition in which people decide whether or not to get health care. And I know lots of people, going back to my VISTA days in West Virginia in the early 1960's, would rather not go to a medical facility and find out more bad news. So they don't go, which is not your purpose.

Thank you, sir.

Chairman SPECTER. Thank you very much, Senator Rockefeller.

Senator Graham, you have not had a second round yet.

Senator GRAHAM. Thank you, Mr. Chairman. I would just like to return to the subject I broached earlier, and that is the area of a very major and growing concentration of veterans: the panhandle of Florida.

There seems to be Administration support for a new hospital in Pensacola. I wonder if someone could give a status report on that and allay my concerns that there didn't seem to be any reference to that in either the CARES report or in the Commission's review.

Dr. ROSWELL. Are you speaking to the Pensacola Naval Hospital which would have a joint presence with the VA?

Senator GRAHAM. Yes.

Dr. ROSWELL. We are working closely with the Navy and currently have a very productive sharing agreement with the Pensacola naval facility. The expectation is that the new facility would have a VA sharing presence. What form that will take—it would be premature to describe that in detail at this point, but we will be happy to provide some follow-up information.

Senator GRAHAM. I am familiar with the hospital in Albuquerque, which is a shared VA-Air Force hospital. Is that essentially what you are—

Dr. ROSWELL. The concept could take the shape of the one in Albuquerque. We have actually just completed with DoD—in fact, I was briefed this morning following the 2002 Defense Authorization Act which requires an evaluation by an independent contractor of joint governance. One of the areas looked at was the Gulf Coast area. We now have a planning model that looks at both VA and DoD workload and how that is managed.

So it could be an integrated facility. It could be on a contractor basis where VA would reimburse Navy for that care. It could be a

joint facility. Those types of decisions would come with further planning which is scheduled.

Senator GRAHAM. Would you anticipate that this issue, as well as planning for long-term care, would be incorporated in the final CARES report?

Dr. ROSWELL. I don't think it would, sir. I think that these are decisions that would be in the implementation planning and the continuous strategic planning process. Because it is not specifically addressed as a proposal in the draft National CARES plan which the commission used to formulate and frame their recommendations to the Secretary, I would anticipate a specific recommendation.

But I can assure you that there is active sharing at the Pensacola facility. There is a very productive relationship and it is something that the Joint Executive Council between VA and DoD, as well as the Health Executive Council, is monitoring on a continuous basis.

Senator GRAHAM. What was the criteria to determine which programs were officially and formally part of the CARES process and which were not?

Dr. ROSWELL. The CARES process utilized a variety of criteria, but basically there was a planning model. If there were significantly gaps, it basically used an actuary to project the veteran population and the demand for care in the years 2012 to 2022. It then overlaid that demand for care with the current infrastructure within VA and the capacity associated with that infrastructure. If there was a gap of more than 25 percent, either 25 percent excess capacity or 25 percent insufficient capacity, then it had to be addressed specifically in the planning model.

In the case of Pensacola, most of that care, as you may know, is provided through the Gulfport-Biloxi VA Medical Center, which is responsible for the current VA Pensacola outpatient clinic and is also the oversight or the parent facility for the sharing situation with the Pensacola naval hospital. I can't tell you with certainty, but my expectation is because there was not a 25-percent gap in that parent facility, it didn't fall out as a separate planning initiative.

Senator GRAHAM. Just briefly, with 45 seconds left, would the same rationale have applied to the long-term care issue?

Dr. ROSWELL. No, sir. The long-term care wasn't even included in the model because, working with our actuary, we couldn't adequately project it at that time.

Senator GRAHAM. But do you think that it will be incorporated in the final CARES report?

Dr. ROSWELL. Long-term care will not be incorporated as far as specific recommendations, but the strategic planning process will address that on an ongoing basis.

Senator GRAHAM. And what is the time line of CARES and the strategic planning model?

Dr. ROSWELL. The Secretary is expected to make this final decision with the CARES plan on or about March 12, at which point in time we would go into an implementation plan. That would also commence a strategic planning process which should be a contin-

uous strategic planning process that we will validate and update on a year-to-year basis.

Chairman SPECTER. Senator Graham, I would like to go back to the time limits so we can move along. We had deviated with Senator Hutchison, who made no opening statement and had a very important issue. But we are going to try to stay within the confines of the time limits.

Senator HUTCHISON.

Senator HUTCHISON. Thank you, Mr. Chairman.

I want to go back to where we left with regard to the recommendation that there be a new multi-specialty outpatient clinic constructed in the Waco area and ask if you did consider renovating the existing space already owned by the VA and if that would be an alternative that would save taxpayer dollars, while staying in the same area for service.

Mr. ALVAREZ. Senator, we asked that question and the general consensus, without any specific detail, was that it would be far more expensive. Let's put it this way: it would be far less expensive to go ahead and build a new, modern, up-to-date multi-specialty outpatient clinic there either on the campus or off the campus somewhere to serve those veterans than to try to renovate those buildings.

That facility was built in 1932. It is 1932-era construction. Everything is interconnected with all the building, all the heating, electrical. It is a nightmare of a problem, and so I don't believe they went further into it. I guess that basically was the extent of our probing.

Senator HUTCHISON. Did you base it on any figures that would be given in the cost of renovation, particularly if there were other buildings filled that would take away some of the operational inefficiencies?

Mr. ALVAREZ. No, Senator, but we do know that that is one of the factors that the city task force was going to look into and work with the VISN director on that.

Senator HUTCHISON. So in your mind, would it be an open issue whether renovation could be done on a more cost-efficient basis than building a new facility?

Dr. ROSWELL. If I may, Senator, generally speaking, renovating 50-year-old buildings, because of the issues Chairman Alvarez brought up, is more costly than new construction. I think a better way to frame the question would be that new construction would take place on the current Waco campus or off-campus.

Senator HUTCHISON. Exactly. I was just going to say the next step is, then, are you talking about buying real estate when you are looking at the—

Dr. ROSWELL. Not necessarily. The Waco campus is costly to operate because of its size. There are over 100 acres. There are numerous buildings and that is where the excess cost of operation comes in. If we found a sharing partner that would want to manage the entirety of that campus, then it probably would be more cost-efficient to move off campus with new construction.

For example, if our regional office wanted to come in and relocate their offices there, which is a very large office in a Federal building

in downtown Waco, then it might be more costly to build a new outpatient clinic on the existing acreage that VA currently owns.

Senator HUTCHISON. Cost-efficient, you mean?

Dr. ROSWELL. Cost-efficient.

Senator HUTCHISON. Yes. I am looking for areas where there might be, with the community input, some way to go.

Let me just talk again about the blind rehabilitation center. When we were there, they had just done about a \$10 million renovation, a state-of-the-art facility. And now the recommendation was to move that away, again, taking away another service that is done that would create synergy, moving it possibly to Dallas or Temple, or they were even talking about Mississippi.

That didn't make sense on its face, particularly with Temple being 30 minutes away and having the ability to have medical students in Waco just about as easily as you have them in Temple.

Mr. ALVAREZ. Can I answer that?

Senator HUTCHISON. Yes.

Mr. ALVAREZ. In keeping with the total plan to move all the programs off that campus, the proposal with regard to the blind center was discussed at the hearing and the VISN directors really did not want to consider Dallas, as it was farther away for a lot of the veterans.

His objective would be to move it closer to where the majority of the veterans live, possibly the Austin area, because they do serve a lot of people from the lower Rio Grande Valley and it would be closer to them, also.

Senator HUTCHISON. Again, if you were going to try to create a synergy of efficient service on that campus, keeping that there, having your new multi-service outpatient facility, you could work something if you were trying to do that.

Dr. ROSWELL. It is possible. Let me point out that the synergy with blind rehabilitation—

Chairman SPECTER. Dr. Roswell, the time is expired, but you may finish your answer.

Dr. ROSWELL. The synergy with blind rehabilitation has to do with access to optometrists, to ophthalmologists, to psychologists, a variety of specialties that may be located in a more full-service acute care facility such as the one in Temple.

If the University of Texas medical branch at Galveston were to create a significant new medical school presence in the Austin area, that would probably create an ideal site for a blind rehabilitation center, as well as some of the acute and long-term psychiatric facilities that Dr. McCormick spoke of.

Chairman SPECTER. Thank you very much. We will have a third round.

Will one more round be sufficient for your purposes, Senator?

Senator GRAHAM. I waive an additional round.

Chairman SPECTER. Senator Hutchison, will a third round be sufficient?

Senator HUTCHISON. Yes, I think so. I have so many areas to cover, Senator.

Chairman SPECTER. Well, we can always submit questions for the record, if you have them.

Senator HUTCHISON. Thank you.

Chairman SPECTER. Chairman Alvarez, coming down to Butler, in 1997 the Butler VA facility had 28 inpatient beds to care for 10,000 veterans. Today, it has 8 beds and it cares for 18,000 veterans. Butler does not have any unused buildings on the campus. Some of them have been aggressively disposed of by way of leases to the United Way-Butler County and Catholic Charities.

Is the commission's action with respect to Butler the same as it is with respect to Altoona, and that is a recommendation, in effect, to see what happens over a protracted period of time?

Mr. ALVAREZ. No, sir. I will let Commissioner Vogel address that.

Mr. VOGEL. Thank you, Chairman Alvarez.

Senator SPECTER, at Butler their average daily census right now is between 3½ and 4 patients a day in acute medicine. About 96 percent of the patients there receive outpatient care only. As you know, in western Pennsylvania they are about 38 miles from Pittsburgh. They do have contractual relationships in place now.

Chairman SPECTER. Have you traveled that road, Route 8, from Butler to Pittsburgh?

Mr. VOGEL. I certainly have. I am from western Pennsylvania, sir.

Chairman SPECTER. You are from where?

Mr. VOGEL. I am from western Pennsylvania.

Chairman SPECTER. Are you from Butler?

Mr. VOGEL. Part of my family is in Butler, sir.

Chairman SPECTER. Where is your home, Commissioner Vogel?

Mr. VOGEL. My home now? Charleston, South Carolina.

Chairman SPECTER. When did you last travel Route 8 from Butler to Pittsburgh?

Mr. VOGEL. Last summer, when we visited there.

Chairman SPECTER. How long did it take you?

Mr. VOGEL. It took us about 55 minutes, 60 minutes.

Chairman SPECTER. Were you speeding?

[Laughter.]

Mr. VOGEL. No. We were driven by Butler VA Medical Center police officers, who were very assiduous to the—

Chairman SPECTER. I am going to fire my driver. I have never made it in 55 minutes.

Mr. VOGEL. Well, the point was that Butler Memorial Hospital, in part, has arrangements now with VA to take care of emergency patients and some others. Our proposal was predicated on the opportunity to maintain the long-term care facilities there, the domiciliary, the nursing home. They are busy facilities. They did about 165,000 outpatient stops last year. So no question, it is a busy facility.

Chairman SPECTER. Mr. Vogel, are you aware that Butler has plans to allow the Butler Memorial Hospital to relocate at the VA?

Mr. VOGEL. Yes, sir.

Chairman SPECTER. Wouldn't that change your view as to what ought to happen with the VA?

Mr. VOGEL. I think the view of that would be that they have a great opportunity for enhanced use arrangements with Butler Memorial Hospital, and if that is achieved, they could receive some real economies of scale by sharing and purchasing services together—dietetic service, engineering service, lab, pharmacy. I think

we saw that as a very viable opportunity, and the CEO of Butler Memorial Hospital met with us both on a site visit and at the hearing.

Chairman SPECTER. Well, at a minimum, shouldn't the VA be able to stay in Butler at least until they complete their negotiations with Butler Memorial Hospital?

Mr. VOGEL. Yes, Mr. Chairman. Throughout, our caveat has been the VA ought not to do anything that would reduce access until all things are positioned and in place through referrals and VA contracts with community providers and other arrangements to care for those veterans.

We really spent a great deal of effort and time on the "E" part of CARES, the enhanced service part of it, and believe with the recommendations we have made we can achieve those things.

Chairman SPECTER. With respect to the recommendations made as to Erie, Chairman Alvarez, are they the same as the recommendations made as to Altoona?

Mr. ALVAREZ. Yes, they are, Senator.

Chairman SPECTER. They are the same for Altoona, so that you want to wait and see what happens over a prolonged period of time, until 2012 or 2014?

Mr. ALVAREZ. Yes, sir. And besides that, there is something happening in that area, also. The VA is opening new CBOCs in that northwestern corner, and one of the factors that we cautioned or recommended that they do is keep track of what is happening with regard to those new CBOCs with respect to referrals from the CBOCs to Erie. The referral pattern may change the demand on that, in addition to the projected workload demand. So all of that is cautionary.

But you are right; it is keep an eye on what is happening. Of course, we basically said, you know, when feasible, when reasonable, when you see the patient enrollment population declining quite a bit, then go ahead and make your decision. But beyond that, we didn't micromanage it. We said that is the decision by the VA's management. They are fully capable and we respect that.

Chairman SPECTER. So it might take as long as 2012 or 2014, as Dr. Roswell testified to?

Mr. ALVAREZ. Or perhaps longer if the conditions change.

Chairman SPECTER. We may have another hearing, then, sometime around that period of time.

Senator HUTCHISON.

I want to go to Big Spring. You recommended doing the feasibility study to determine what should be done with Big Spring, but you have got a situation here where Big Spring is 40 miles from Midland, 60 miles from Odessa, 57 miles from San Angelo, and 100 miles from Abilene. If you closed that facility, the closest place that those people in west Texas would have—and all of those are fairly large communities—would be San Antonio or Dallas.

So my question is wouldn't it make more sense to work with the Scenic Mountain Medical Center, which is a good, solid medical center in Big Spring, and create a public-private partnership that would give a service to the west Texas veterans community in a more efficient way? Just leave the status quo on the acute care, but

keep the hospital for all of those surrounding communities—is that a feasible suggestion? We have done a lot of studies on this already.

Mr. Alvarez or Dr. Roswell, either of you.

Dr. ROSWELL. Certainly, my understanding of the commission's recommendation and our expectation is that we need to study exactly where best to situate inpatient services for veterans in the west Texas area.

Thanks to your office, I have become keenly aware of the referral patterns from San Angelo and Abilene and the fact that the Big Spring location, while not a populace area, per se, is centrally located between the entire patient population that is served by that medical center.

I can readily grasp some of the disadvantages of moving such a facility to the Midland-Odessa, and I think a study would need to look not only at the utilization of services, but clearly the referral patterns in siting that. One of the things that we would be very interested in is identifying in any location, but particularly where we have a relatively low workload, a sharing partner where we could generate efficiencies by collaboration or sharing.

Senator HUTCHISON. Like the private clinic.

Dr. ROSWELL. Exactly, just as you have mentioned, yes, very much so.

Mr. MCCORMICK. I happen to have been at the hearing that dealt with Big Spring, and I think if you read the report hopefully it would reflect that we heard a lot of very compelling testimony actually about the centrality of Big Spring, very similar to what you said, both from the State veterans director as well as some of the veterans service organizations, and the reality that the other advantage of the Big Spring location is that there is a relatively new, I believe, State veterans home there that was put there, according to the State director of veterans affairs, specifically because of the hospital.

So while we concurred with the study, I think if you read the report, we also tried to make it very clear that we thought that study had to take very much into account the knowledge base of the people on the ground that are there. Most of the testimony we heard was in favor of the Big Spring location.

Senator HUTCHISON. Even the Midland-Odessa leadership, I think, agrees on that. Well, I thank you for putting that in the record because that is helpful.

In summary, on Waco, I think we have a lot of different issues with regard to Waco. But if we said that the VA has a large investment there in both facilities and real estate and we were going to try to make the best use of it and that we could look at the new multi-service facility, whether it is a new building or renovating the old buildings—and I am not convinced that we have enough data on that yet, but say it is probably more feasible to build it on that campus rather than buy new real estate and that you could make it more efficient by moving other things in there, which the community is certainly willing to work to do, as well, perhaps even medical servicing-type facilities.

The one thing that we didn't talk about too much was adding a nursing home-elder care facility, which I think you had mentioned.

Is that something that could be added to? And, second, is that something that the older buildings are more amenable to as a use than maybe some of the other inpatient-type care needs?

Mr. MCCORMICK. Let me just take a shot at it. First of all, let me start off by saying we have not only an investment in real estate in Waco, we have an investment in a community of seriously mentally ill patients.

One of the realities is when we built places like Waco or Chillicothe and other places, we ended up deinstitutionalizing a lot of patients into the communities, often into foster care. And we may have 3, 400 patients right now in Waco, for example, and these are generally very high-priority patients.

While I still stand by what I said for acute care, because Austin has that need, I think there are many opportunities—

Senator HUTCHISON. Wait. I understand your point on Austin and not having to wait for ambulance. I understand that.

Mr. MCCORMICK. Right. Let me go back to Waco. I think that the reality goes to your point that given the community of seriously mentally ill patients around there—and they will age and they will require as they age—and the good news is they are living longer because of the medical care and the types of medications we use. They will need long-term care and they have to be addressed and those needs have to be addressed.

That is one of the reasons we put the caveat in about Waco that the issues of long-term care for the Waco population—frankly, the patients they are treating at Waco right now in long-term care are very needy patients, with a wonderful staff taking care of them.

So to answer your question, I think there is clearly a need for a very large outpatient presence, and larger than perhaps you would usually have in that size of an area because of the community of deinstitutionalized patients. And there is an opportunity to look at how best to provide long-term care, and I think both of those things do reflect on the future planning for Waco.

Chairman SPECTER. Thank you very much.

Senator HUTCHISON. Can I just—

Chairman SPECTER. Do you have another question? We have another panel, Senator.

Senator HUTCHISON. I am sorry. I just wanted to clarify that last answer. I am sorry, Senator Specter. I did not know that we were going on.

When you say large outpatient need, you are talking about the multi-service, not just psychiatric, correct?

Mr. MCCORMICK. Yes. I mean, you have both—

Chairman SPECTER. We are over time, Mr. McCormick, but you may answer that question.

Mr. MCCORMICK. Yes. I was saying that in addition to a size that would fit the population for the medical needs, the reality is that because of the special needs of the seriously mentally ill, the outpatient services are already more comprehensive for outpatient mental health and they need to be sized with that in mind. So I am really saying both medical and mental illness.

Senator HUTCHISON. Thank you, Mr. Chairman.

Chairman SPECTER. Thank you very much, Senator Hutchison.

Well, that concludes this panel. I think it has been very informative. As I said last September, if the proposed actions are justified by evidence of wastefulness developed through an objective analysis of individual data relevant to the particular VA facilities, this Committee would not object. But we have many questions raised and I am somewhat relieved to hear that you are not thinking about actions to Erie or Altoona for a protracted period of time, 2012 or 2014.

I am also concerned that we not take a look at facilities just because they are small and they are presumptively inefficient. An article in the Journal of the American Medical Association in its January 14 issue of this year came to the rescue of small facilities. It concluded that small is not, per se, inefficient.

So thank you very much, gentlemen. We will consider your testimony very carefully.

We are going to take a very brief recess and then resume with panel two. So we will set up panel two and we will proceed, as I say, in a few minutes.

[Recess.]

Chairman SPECTER. We will proceed directly to hear from Ms. Cathleen Wiblemo, Deputy Director of Health Care for the American Legion. Thank you for joining us and the floor is yours. I regret the limitation of time to 3 minutes, but I think you are used to it. Thank you.

STATEMENT OF CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR OF HEALTH CARE, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Ms. WIBLEMO. Thank you, Mr. Chairman, for the opportunity to express the views of the American Legion regarding the Capital Asset Realignment for Enhanced Services Commission's recommendations. The American Legion commends the distinguished members of the CARES Commission for their honest effort in analyzing the draft National CARES Plan and assembling the recommendations contained in the report.

The CARES Commission did not shy away from stakeholder input and actively engaged the stakeholder community. The American Legion believes this made a significant difference in some of the recommendations offered by the commission.

Campus realignments were introduced late into the process. These last-minute changes led to a multitude of proposals that were indefinite and contained contingency language that left the status of the services in question. The proposals to shut down facilities were not part of many of the VISN market plans. The American Legion does not believe decisions of this magnitude should be made absent the inclusion of long-term care, mental health and domiciliary projections. Further, no facilities should be closed, disposed of or downsized until the proposed transfer of services is complete and veterans are being treated in new locations.

Finally, the commission recommended that no services should be altered until viable services are identified in the community. The American Legion is in agreement with these recommendations and hopes that stakeholder concerns will be at the center of these initiatives. The VA must establish quality criteria for contracting and

monitoring of service delivery and training of staff to negotiate cost-effective contracts.

The American Legion is fully committed to working with this Committee to ensure that the recommendations resulting from the CARES initiative do indeed result in enhanced services for all of American's veterans and their families.

Thank you. I would be happy to take any questions.

[The prepared statement of Ms. Wiblemo follows.]

PREPARED STATEMENT OF CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR OF HEALTH CARE, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee: Thank you for this opportunity to express the views of the 2.8 million members of The American Legion regarding the Capital Asset Realignment for Enhanced Services (CARES) Commission's Report to the Department of Veterans Affairs' (VA) Secretary. The CARES initiative is unprecedented when considering the broad scope of VA's mission and the effects the final recommendations will ultimately have on VA's ability to fulfill its missions. Implementation of these recommendations will greatly impact services provided, not only to veterans currently seeking timely access to quality health care, but those active-duty military members, serving in more than 130 countries worldwide, who will 1 day turn to VA for care.

The United States military is currently preparing for the largest troop rotation since World War II; therefore, it is imperative that the final recommendations of the CARES report lead to substantive changes for enhanced veterans' services rather than simply downsizing the VA health care system. The recommendations contained in this report will ultimately shape the future of health care delivery within VA. The implementation and integration of those recommendations into the strategic planning cycle over the next 20 years is crucial to ensuring America's veterans, present and future, receive timely access to the quality of health care they have earned through honorable military service to this country.

THE CARES COMMISSION REVIEW AND RECOMMENDATIONS ON THE DRAFT NATIONAL CARES PLAN

After several months of open meetings, lengthy debates on the overall effect of possible recommendations and nationwide VISN specific hearings, the *CARES Commission Report to the Secretary of Veterans Affairs* was finally released in February 2004.

The American Legion is concerned with contingency language contained in the report that does not clarify certain proposed recommendations. Those recommendations that include "proposed feasibility studies" and language such as "transfer or contract inpatient surgery beds" must not be open to loose interpretation. The American Legion supports strong oversight of all the recommendations well into the implementation stages.

The American Legion applauds the distinguished members of the CARES Commission for their honest effort in analyzing this vast amount of information and assembling recommendations for a report of this magnitude.

Stakeholder Involvement—One of the biggest issues of concern during the first phase of CARES was the obvious lack of consideration by VA over stakeholder input. When CARES entered Phase II, it was important to The American Legion to ensure that the voice of the stakeholder was heard during the CARES process. The American Legion took the following measures:

- Appointed a Legionnaire in each Veterans Integrated Services Network (VISN) to serve as its CARES representative with the primary task of participating at the local level regarding the CARES initiative and passing along information pertaining to CARES.
- Appointed members to The American Legion's VA Facility Advisory Committee to the Veterans Affairs and Rehabilitation Commission of The American Legion (VAFACC). The purpose of this Committee was to review the market plans submitted by the VISN leadership and to monitor the progress of the CARES process.
- Members of The American Legion's *A System Worth Saving* Task Force visited the seven facilities targeted for closure between November 1, 2003 and January 1, 2004. As a result of those visits, *A System Worth Saving: The American Legion Report on the Seven Facilities Targeted for Closure in the CARES Draft National Plan* was released on January 26, 2004.

Through the hearing process and along with Internet communications, the CARES Commission was able to solicit stakeholder concerns, and actively sought their views. The American Legion has maintained that stakeholder input is imperative and must be taken seriously at all levels of the CARES process. The American Legion intends on maintaining its participation in this process as both a partner and stakeholder in developing the future of VA health care.

Campus Realignments and Consolidations—The Draft National CARES Plan (DNCP) contained proposals to close seven VA Medical Center campuses and consolidate certain services. These proposals were introduced relatively late in the process, absent stakeholder input. The Commission's recommendations in the report to the Secretary differ slightly with the DNCP, and to the Commission's credit, stakeholder input was sought out at both the local and national level to assist them in their evaluation of the DNCP's proposals concerning the facilities.

The American Legion cannot support the closing of any VA facility and denying veterans access to health care simply for the sake of cost-saving measures. No facilities should be closed, disposed of, or downsized until the proposed transfer of services is complete and veterans are being treated in the new locations.

CANANDAIGUA VETERANS AFFAIRS MEDICAL CENTER

The American Legion disagreed with the recommendation to close the Canandaigua VAMC as proposed in the DNCP. Current services include long-term care, nursing home care, mental health care and alcohol/drug rehabilitation, respite care, the post-traumatic stress disorder clinic, the domiciliary program and the mental health intensive case management program. This facility performs an important role in its region and is critical in meeting the health care needs of the local veterans' community it serves.

The American Legion is relieved to see that the Commission did not concur with the DNCP plan to close Canandaigua VAMC. The Commission recommends that psychiatric long-term care, nursing home care, domiciliary and outpatient treatment remain at Canandaigua. The American Legion opposes any change to services at Canandaigua until accurate demand projections are accomplished. Further, we are pleased to see the recommendation by the Commission that the VISN involve stakeholders and the community to help resolve the challenges they are facing.

LIVERMORE VETERANS AFFAIRS MEDICAL CENTER

The American Legion could not support this proposal as presented in the DNCP. The Menlo Park Division is 40 miles and an hours driving time for many of the older veterans who receive their care in Livermore. The proposal to contract out nursing home care in this area is far from realistic considering the local community does not have the capacity to handle these patients. The Commission recommends retaining long-term care services (nursing home beds) at Livermore as a free-standing NHCU. The American Legion agrees.

WACO VETERANS AFFAIRS MEDICAL CENTER

The American Legion disagreed with the DNCP proposal to eliminate health care services at Waco VAMC. The Commission recommends retaining the NHCU as a VA operated facility, transfer of inpatient psychiatry, blind rehabilitation and PTSD residential rehabilitation to Austin and Temple and the construction of a new multi-specialty CBOC in Waco.

Waco is a multi-VISN referral facility for chronically mentally ill patients and a national referral facility for blind rehabilitation. Again, the CARES model does not incorporate the mental health needs and projections to 2012 and 2022 for veterans. Until the mental health numbers have been included, The American Legion believes the facility should stay open with no change to its mission considered.

VA PITTSBURGH HEALTHCARE SYSTEM, HIGHLAND DRIVE DIVISION

The proposed closing of Highland Drive and the transfer of all services to University Drive and Aspinwall campuses would require considerable and costly construction with estimates of more than \$90 million. Due largely to the very distinct veterans' population Highland Drive VAMC serves, any transition of services could prove detrimental to the veterans' population relying on the services provided. Any proposed transfer of services must be seamless with as little disruption as possible to these veterans. If any proposed transition of services were to take place, The American Legion insists that an adequate amount of time be given to allow an orderly transfer with minimal disruption to patients and families.

LEESTOWN VETERANS AFFAIRS MEDICAL CENTER

The American Legion objected to the DNCP proposal to close the Leestown Campus of the Lexington VA Medical Center. Veterans in this area are woefully underserved in the mental health care area. The closing of the Leestown campus would be a great disservice to veterans in need of mental health services. Once again, The American Legion points to the lack of accurate mental health care projections throughout the VA system. Even if VA does include projections for future mental health care, those figures will not be incorporated until the next strategic planning cycle. The American Legion agrees with the Commission recommendation to keep the Leestown VAMC open.

BRECKSVILLE VETERANS AFFAIRS MEDICAL CENTER

The Commission concurred with the DNCP proposal to close this facility and transfer all services to Wade Park. This raises serious concerns that Wade Park cannot handle the influx of new patients and that many patients will have to forgo treatment. The American Legion is concerned that this facility will close before proper planning and transferring of services has taken place. The chance for disruption of services to veterans is considerable. If the Brecksville VAMC is closed, VA must ensure that facilities at Wade Park are sufficient and operational before any services are discontinued.

GULFPORT VETERANS AFFAIRS MEDICAL CENTER

The American Legion does not support the closing of the Gulfport VAMC as proposed in the DNCP and concurred with by The Commission. Under the plan, all services are to be transferred to Biloxi and Keesler AFB. The American Legion believes the plan relies too heavily upon future developments with no guarantee that they will come to fruition. Biloxi's capacity to handle Gulfport's patient load before 2009 is questionable. Additionally, the Department of Defense (DoD) has made no firm commitment regarding the number of beds they can or will provide at Keesler AFB. Furthermore, gaining access to the base may be restricted because of increased homeland security measures.

Community-Based Outpatient Clinics—The VISN market plans proposed the establishment of 242 new Community Based Outpatient Clinics (CBOCs). To maintain the integrity of the system, and maintain level growth for demand of services and ensure the ability to provide quality care, the DNCP proposed the establishment of only 48 CBOCs prioritized into three groups.

The criteria for inclusion into the top 48 CBOCs: (1) an access gap; (2) projected future increases in workload; and (3) more than 7,000 projected enrollees currently residing outside of access standards per proposed CBOC.

On October 7, 2003, VA's Undersecretary of Health informed the Commission that priority groups for CBOCs were established in order to continue limiting any new enrollees to prevent any strain on the inpatient infrastructure. The Commission noted that this has the effect of limiting access to outpatient care and is contrary to the goals of CARES to better serve veterans today and in the future.

The American Legion agrees with the Commission's recommendation that new CBOCs be established without regard to the three priority groups outlined in the DNCP. The American Legion believes funding for construction of new CBOCs should come from additional discretionary construction appropriations. Currently, VISNs and facilities struggle to maintain timely access to quality health care for veterans, especially when inadequate annual VA medical care appropriations are consistently finalized well into the new fiscal year. In the fiscal year 04 VA medical care budget, Congress will allow the transfer of \$400 million for CARES recommendations. The American Legion disagrees with this budgetary practice. For several years, VA Construction, both major and minor, was under funded pending the approval of CARES recommendations. This "robbing Peter to pay Paul" approach is inappropriate budgetary shenanigans. CARES' "enhanced services" construction funding should fall under VA Construction.

Long-Term Care, Mental Health, Domiciliary—VA provides specialized and unique care to veterans. It has been shown that the veterans' population cannot accurately or fairly be compared to the general patient population. The VA patient community is an older population that experiences a myriad of co-morbidity issues that complicate treatment.

CARES is a data driven process. The key component is the data used to forecast the future needs of veterans. The CARES process fails to include information on long-term care, outpatient mental health and domiciliary needs of veterans. VA chose to omit these important health care needs for this assessment. The American

Legion believes these critical omissions adversely impact the effectiveness of recommendations resulting from the CARES process. The exclusion of these issues in the CARES process denies a complete and accurate picture of the demand for these services.

A case in point is the disparity in demand estimates for nursing home beds in VISN 6's Northwest Market. CARES DNCP estimates held that the veterans' population in this Market is expected to decline from 53,000 in fiscal year 2001 to 48,000 in fiscal year 2012, and to 39,000 in fiscal year 2022. Consequently, the CARES Commission found that "current LTC workload at Beckley WV is decreasing and does not indicate that more nursing home care beds are needed."

This would appear to contradict a 2002 Capital Effectiveness Analysis (CEA) conducted by VA's own Office of Policy and Planning in collaboration with the Geriatrics and Extended Care Strategic Healthcare Group, the Agency for Health Care Policy and Research and the University of Michigan. Also cited in the DNCP in a VISN Identified Planning Initiative, the CEA study projected "the elderly population in West Virginia to increase from 15.3 percent in 1995 to 24.9 percent in 2025, which will put a strain on the private sector nursing homes in the area." The closest State Veterans Home is 100 miles away and Beckley VAMC Extended Care and Rehabilitation Service Line management is precluded from using a majority of local nursing facilities because of patient safety and quality of care concerns. A new 120-bed nursing home was approved for Beckley and initial phases of the project are now underway. As a fait accompli, the Commission concurred with the project. It is clear, however, that if only CARES data were used to estimate NHC bed demand, current capacity would have been deemed adequate and many aging veterans in eastern West Virginia would be denied safe, quality nursing home care in the coming years.

The example of Beckley is illustrative of problems with the CARES model as applied to long-term care where variables, such as aging trends, are not part of the equations. Similar flaws exist in demand projections for mental health services and domiciliary. The American Legion insists that decisions on services in these areas be deferred until accurate projections are available.

Vacant Space—According to VA's Office of Facilities Management (OFM), VA facility assets include 5,300 buildings, 150 million square feet of owned and leased space, 23,000 acres of land and a total replacement value estimated at \$38.3 billion. The Draft National CARES Plan proposes to eliminate 4.9 of 8.5 million square feet of vacant space, an ambitious 42 percent, by fiscal year 2022. The DNCP calls for divestiture and demolition early in CARES implementation as the primary methods to reduce vacant space. The Commission notes that much of VA's excess property is not contiguous, but consists of pockets of space scattered throughout campuses, making it useless for other purposes such as Enhanced Use Leasing. Many VA buildings are considered historic, further challenging VA's disposal of the properties. The American Legion agrees with the Commission's findings that separate appropriations are requested to stabilize and maintain historic property rather than rely on medical care appropriations.

The American Legion does not agree with the Commission's finding that VA "... aggressively pursue disposal of excess VA property and land." The American Legion believes a case-by-case effort should be made to consider alternative uses of any vacant space before it is eliminated, such as: services for homeless veterans, long-term care, and the expansion of existing services.

Contracting Care—The DNCP proposed extensive contracting out of care within many of the VISNs in order to meet the projected increased demand in services through the peak years. Contracting out of care is necessary in some circumstances and inevitable in others, given VA's inability to pay competitive salaries to medical professionals. The American Legion agrees with the Commission's recommendation that no services should be altered until viable services are identified in the community. Furthermore, VA must establish quality criteria for contracting and monitoring service delivery and training of staff to negotiate cost-effective contracts. Fee schedules must be reviewed and adjusted to attract qualified practitioners; otherwise Medicare/Medicaid style difficulties in retaining contract providers may be experienced by VA.

Enhanced Use Lease Agreements—With Enhanced Use Lease Agreements (EULs) VA can maximize returns from property that is not being fully utilized. EULs allow VA to reduce or eliminate facility development and maintenance costs. Through effective use of EULs, VA can receive cash or "in-kind" consideration (such as facilities, services goods, or equipment).

The DNCP proposed several enhanced use lease agreement projects with the public and private sectors. Uses include homeless shelters or housing, cultural arts center, cemeteries, inpatient beds, mental health services and many other veterans'

service enhancing ideas. The American Legion believes that EUL agreements that result in the development of new strip malls, commercial office buildings, or hotels come at the expense of providing real “enhanced services” to veterans.

The American Legion recognizes that the EUL process, noted by the Commission, is fraught with delays, and a lack of demonstrated confidence and insufficient expertise to attract potential investors or navigate local zoning and land use requirements, is lengthy and complex, and is subject to the ups and downs of local economic conditions. The American Legion agrees with the Commission’s finding that the EUL process needs reform.

VA/DoD Sharing—There are many opportunities for sharing between VA and the Department of Defense (DoD). The DNCP contains 21 high priority collaborations/joint ventures out of the 75 proposed throughout VA. Both VA and DoD benefit from these agreements and every effort should be made to pursue this avenue in order to save money through cost avoidance, in particular pharmaceuticals, supplies and maintenance services.

Extra effort on the part of these agencies to cooperate is essential in order for sharing to be successful. There is reluctance in some parts of the country to “share” services or programs between agencies. It is imperative that these roadblocks are overcome.

The American Legion agrees with the Commission’s premise that VA/DoD collaboration should be one of the first considerations in addressing health care needs in a local area. However, the focus should always be on providing quality healthcare and reasonable access to the nation’s veterans. If in the VA/DoD sharing process that cannot be accomplished, other ways of providing the service must be evaluated and the one that most benefits the veterans’ community is the option that should be exercised.

Medical School Affiliations—VHA conducts the largest coordinated education and training program for health care professions in the nation. Medical school affiliations allow VA to train new health professionals to meet the health care needs of veterans and the nation. Medical school affiliations are a major factor in VA’s ability to recruit and retain high quality physicians and to provide veterans access to the most advanced medical technology and cutting edge research. VHA’s research has made countless contributions to improve the quality of life for veterans and the general population.

VA’s partnership with this country’s medical schools continues to allow VHA to enhance its ability to provide quality medical care to America’s veterans, to promote excellence in education and research, and to provide back-up medical care to DoD in the event of war or national emergency.

The academic medical model of integrated clinical care, education and research is universally accepted as the best means of providing high quality and state-of-the-art medical care. The American Legion affirms its strong commitment and support for the mutually beneficial affiliations between VA and the medical schools of this nation. VA medical school affiliates should be appropriately represented as a stakeholder on any national Task Force, Commission, or Committee established to deliberate on veterans’ health care.

The Fourth Mission—VA’s fourth mission is to serve as back up to DoD in the case of a national emergency. Any recommendations that are implemented as a result of the CARES initiative must ensure that VA is capable of fulfilling the fourth mission.

IMPLEMENTATION AND INTEGRATION INTO STRATEGIC PLAN

CARES will not end once the Secretary renders his decision. It is expected to continue into the future with periodic checks and balances to ensure plans are evaluated, as needed, and changes are incorporated to maintain balance and fairness throughout the health care system. Service areas such as long-term care, mental health services and domiciliary capacity, excluded from the CARES process, were to be dealt with in strategic planning. The American Legion notes that VA’s July 2003 Strategic Plan 2003–2008 contains a scant two paragraphs of generalities on the subject of long-term care. The American Legion will be following these issues closely in the coming months and years.

Mr. Chairman and Members of the Committee, The American Legion has raised many concerns today. The recommendations to close VA hospitals during a time when hundreds of thousands of soldiers are being sent to foreign lands to fight a war and the assessment of long-term care, mental health and domiciliary services being pushed back to the next cycle of CARES, are serious flaws in an assessment of a system vital to the health care needs of this nation’s veterans. The American Legion has strong reservations against the contracting of veterans’ care. The Nation

is producing more and more veterans in the global fight against terrorism, a fight that promises to be lengthy and take its toll on our young men and women. Unfortunately, many of these new wartime veterans will be dependent on the VA health care delivery system for the rest of their lives due to service-connected disabilities. It is imperative that we work together to ensure a future system of health care that meets the needs of the veterans' community.

Mr. Chairman, this concludes my testimony. I again thank the Committee for this opportunity to express the views of The American Legion on the CARES Report and look forward to working with you and your colleagues to ensure that the recommendations resulting from this unprecedented initiative do indeed result in "enhanced services" for all of America's veterans and their families.

Chairman SPECTER. Thank you very much for that testimony.

We turn now to Mr. Dennis Cullinan, National Legislative Service Director for the Veterans of Foreign Wars. Thank you for joining us, Mr. Cullinan. We look forward to your testimony.

STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Thank you very much, Mr. Chairman. On behalf of the Veterans of Foreign Wars and our Ladies Auxiliary, we thank you for holding today's most important hearing and for inviting our participation. I will provide a brief synopsis of my written presentation.

The VFW recognizes that the location of mission of some VA facilities may need to change to improve veterans' access and to allow more resources to be devoted to medical care rather than upkeep of inefficient buildings and to adjust to modern methods of health care service delivery. Therefore, the VFW is generally supportive of the CARES Commission's recommendations.

However, we have identified certain recommendations that, if adopted, in our view, would hamper or even jeopardize veterans' access to quality, timely health care. In addition, as has been observed here today, CARES' methodology, statistics and facts that it has used are far from certain. We believe that all due caution and care have to be invested in the best service of America's veteran patients.

That concludes my testimony, sir.

[The prepared statement of Mr. Cullinan follows:]

PREPARED STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

On behalf of the 2.6 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to thank you for the opportunity to present our views regarding the CARES Commission recommendations.

The CARES Commission was chartered to make specific recommendations to the Secretary of Veterans Affairs on the Under Secretary for Health's Draft National CARES Plan (DNCP) regarding the realignment and allocation of capital assets necessary to meet the demand for veterans' health care services over the next 20 years. The Commission was to accept, modify or reject the recommendations of this draft plan. In making its recommendations, the Commission was told to focus on the accessibility and cost effectiveness of care to be provided, while at the same time ensuring that the integrity of VA's health care and related missions is maintained, and any adverse impact on VA staff and affected communities is minimized.

To understand the impact of the DNCP on local markets, the Commission conducted 38 public fact-finding hearings where testimony was received from local Veterans Service Organizations, employee organizations, academic affiliates, organizations with collaborative relationships and involved elected officials. The VFW was

pleased to have local representatives participate in 30 of those hearings. While all of the recommendations certainly deserve individual attention, I will focus my remarks on some of the recommendations that we believe are representative of the national plan. I would refer the Committee to our statements before the CARES Commission for a more robust and complete analysis of the recommendations regarding each specific market.

We recognize that the location and mission of some VA facilities may need to change to improve veterans' access; to allow more resources to be devoted to medical care, rather than the upkeep of inefficient buildings and to adjust to modern methods of health care service delivery. Therefore, the VFW is generally supportive of the CARES Commission's recommendations, however, we have identified recommendations, that if adopted could jeopardize veterans' access to quality, timely healthcare.

The VFW is concerned with recommendations to curtail VA operations in Pennsylvania by closing a branch of the VA Pittsburgh Health System and scaling back operations in Butler, Altoona and Erie. The recommendations would:

1. Close the hospital on Highland Drive in East Liberty in Pittsburgh.
2. Close acute care services in Butler, Pennsylvania.
3. Close all acute care beds in Altoona, Pennsylvania.
4. Close inpatient surgical services and all acute care beds in Erie, Pennsylvania.

The VFW supports the first recommendation but is opposed to the remaining recommendations. The consolidation of Highland Drive Division's inpatient service to the University Drive campus over the past few years resulted in vacant buildings at the Highland Drive campus. Since considerable consolidation of services has already taken place and the facilities are in close proximity, veterans and stakeholders expressed support for the enhancement of service that the proposed consolidation would bring. Further recommendations would require a veteran residing in Altoona, Butler or Erie to travel to Pittsburgh to receive care they once received locally. This rationing of services is unacceptable. No veteran, who is sick and/or elderly, not to mention their family, should have to drive over 250 miles round trip from Erie to Pittsburgh. This approach is inequitable as it is overly burdensome for the veteran and quite convenient for the VA.

Turning to the Northeast, the VFW agrees with the Commission's recommendation to create and provide additional services in Boston, MA, as well as maintain and not close the Canandaigua VA Medical Center for veterans within that primary service area. As for Montrose, N.Y., the VFW supports moving several services to Castle Point but would further suggest developing a long-term strategic plan for accomplishing the move that would ensure the seriously mentally ill patients are not lost in the shuffle. As for the recommendation regarding Manhattan/Brooklyn, N.Y., the VFW opposes the possible consolidation of these two facilities noting the hardship it will cause for elderly veterans living on fixed incomes who have no means of transportation.

Further south, the VFW generally supports the commission's recommendations regarding Beckley, WV, facility. We agree that multi-specialty outpatient services should remain at this small facility and we would also support a new nursing home because long-term care is needed in WV. The VA must ensure that contracting is feasible and that the local community can effectively provide the necessary services. While in Florida, the VFW supports the construction of a new bed tower in Gainesville while retaining inpatient services at Lake City.

In the Midwest, the VFW is opposed to the closure of the VAMC in Brecksville, OH. The recommendation would transfer functions currently performed there to Wade Park. This will not only add to travel time of the patients now receiving care at Brecksville, it will also exacerbate an already intolerable parking situation at the Wade Park facility.

Finally, out West in Texas, the VFW is concerned with the closure of the WACO VAMC. We would reiterate veterans' concerns regarding travel and access. The VA is in a much better position to go to the veteran rather than the veteran to the VA.

It is important to point out that the VFW believes that any action to reconfigure or expand long-term care or mental health facilities should be developed in a strategic plan because the DNCP originally ignored these service areas. This plan should be based on well-articulated policies and address access to services.

Mr. Chairman, this concludes my remarks and I would be pleased to respond to any questions you or the Members of the Committee may have.

Chairman SPECTER. Thank you very much, Mr. Cullinan. I agree with what you say. They really haven't made their case, and we ap-

preciate your coming in to give us the view of the veterans. We always appreciate your help.

We turn now to Ms. Joy Ilem, Assistant National Legislative Director for Disabled American Veterans.

**STATEMENT OF JOY J. ILEM, ASSISTANT NATIONAL
LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS**

Ms. ILEM. Thank you, Mr. Chairman. We appreciate the opportunity to present the views of the Disabled American Veterans regarding the recommendations of the CARES Commission report.

Access to high-quality, timely health care services is essential for many DAV members. Therefore, the preservation of the integrity of the VA health care system and its specialized programs is of the utmost importance to DAV and our members.

We concur with many of the commission's recommendations relative to the identified cross-cutting issues, and we are also pleased that the commission addressed many of our concerns, specifically the need for further development of the CARES model and projections for mental health care services, the need for VA to develop a more cohesive long-term care strategy, and the need for reassessment of the proposed placement of domiciliaries and associated programs.

We will continue to rely on the expertise of our members to make recommendations regarding the VA medical facilities they use and rely on. Our members are intimately familiar with the unique elements and the impact on each VISN and the medical centers and the CBOCs within their local areas.

From a national perspective, we are opposed to facility closure and consolidation or transfer of services at any location for purely budgetary reasons. VA must ensure, in cases where these decisions are determined to be the only reasonable option, that resources and alternate access to care options are in place prior to the realignment or transfer of services. Under no circumstances should veterans experience a decrease in primary or specialty care services, or denied access to specialized programs.

Oversight by Congress, veterans and veteran service organizations is going to be essential to the overall success of this important initiative. Although we agree with the commission that the final plan should be national in scope, we hope there is sufficient consideration given to the concerns expressed by veterans and other stakeholders as the Secretary makes his final decision.

That concludes my statement. Thank you.

[The prepared statement of Ms. Ilem follows:]

**PREPARED STATEMENT OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR,
DISABLED AMERICAN VETERANS**

Mr. Chairman and Members of the Committee: On behalf of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express the national views of the organization on the Capital Asset Realignment for Enhanced Services (CARES) February 2004 *Report To The Secretary Of Veterans Affairs*. The CARES Commission was established by Department of Veterans Affairs (VA) Secretary Anthony J. Principi as an independent body to review the Draft National CARES Plan (DNCP) regarding the realignment and allocation of capital assets necessary to meet the demand for veterans' health care services over the next 20 years.

The Veterans Health Administration (VHA) is the largest direct provider of health care services in the United States and offers specialized care that is world renown

to veterans with amputations, spinal cord injury, blindness, posttraumatic stress disorder, and brain injury. In recent years, VHA has established itself as a leader in the delivery of quality health care and is also the nation's primary backup to the Department of Defense (DoD) in time of war or domestic emergency. According to VA, the goal of CARES is to enhance access to health care services for our nation's veterans, while insuring the integrity of its health care system. One of the most important VA benefits for service-connected veterans is health care. Access to high quality, timely health care services is essential for many DAV members, especially those who have suffered severe or catastrophic disabilities as a result of their military service. Therefore, preservation of the integrity of the VA health care system and its specialized programs is of the utmost importance to the DAV and our members.

DAV is looking to CARES to provide a framework for the VA health care system that can meet the needs of sick and disabled veterans now and into the future. From a national perspective, DAV firmly believes that realignment of capital assets is critical to the long-term health and viability of the entire VA health care system. We do not believe that restructuring is inherently detrimental; however, we are dedicated to ensuring the needs of special disability groups are addressed and remain a priority throughout the CARES process. As CARES has progressed, we have continually emphasized that all specialized disability programs and services for spinal cord injury, mental health, prosthetics, and blind rehabilitation should be maintained at current levels as required by law.

The Commission stated in its report that CARES is the most comprehensive assessment ever undertaken by VA to determine the capital infrastructure needed to provide modern health care to veterans now and in the future. DAV agrees with the Commission that the CARES process is extremely important as it will impact the system and the delivery of health care services to veterans for decades. Like veterans of previous wars, many of the men and women serving today in our Armed Forces in Iraq, Afghanistan, and other hot spots around the world, will need and depend on the VA health care system. It is our obligation to ensure they have access to a strong and viable health care system, dedicated specifically to their health care needs.

Initially, we want to recognize and thank the members of the CARES Commission for their intensive effort in analyzing the vast amount of information associated with CARES and for the Commission's thoughtful report. DAV believes the Commission conducted a rigorous and thorough review of the available information provided by the National CARES Program Office given the timeframe limitations and provided a comprehensive assessment and analysis of the CARES data and the DNCP. It is apparent in the Commission's final report that many of the concerns expressed by the DAV and other veterans service organizations (VSOs) were addressed during deliberations and included in its final recommendations.

In our testimony, we will refrain from commenting on specific recommendations made by the Commission relating to consolidation, closure, transferring, or realignment of services at individual facilities or Veterans Integrated Service Networks (VISNs). Testimony provided by DAV members at the 38 formal hearings conducted by the Commission will serve as the official position related to proposals made in the DNCP for specific regions or medical facilities. Rather, our remarks will focus on the crosscutting issues identified by the Commission in its report, including facility mission changes, community-based outpatient clinics (CBOCs), mental health services, long-term care, long-term mental health care, excess VA property, contracting for care, infrastructure and safety, research, education and training, special disabilities programs, and VA/Department of Defense (DoD) sharing.

FACILITY MISSION CHANGES

There were a number of instances where the DNCP proposed consolidation or realignment of services, closure of inpatient services, or closure of existing services, including long-term care services. In some cases, the Commission rejected the DNCP proposals, other times it concurred with them, made its own recommendation, or suggested additional study prior to a final decision.

DAV will continue to rely on the expertise of its members to make recommendations about the VA medical facilities they use and rely on. They are familiar with the unique elements that impact each VISN, VA Medical Center (VAMC) and CBOC in their local area taking into consideration the local terrain, specific challenges due to urban, rural, or highly rural areas, local weather conditions, and various other factors.

From a national perspective DAV is opposed to facility closure, consolidation or transfer of services at any location for purely budgetary reasons. VA must ensure,

in cases where these decisions are determined to be the only reasonable option, that resources and alternate access to care options are in place and available to veterans prior to the realignment. Under no circumstances should there be a decrease in services or denied access to needed programs and services. Additionally, careful consideration must be given to ensure transportation to alternate facilities is available and that services are not interrupted for veterans who need them.

COMMUNITY-BASED OUTPATIENT CLINICS (CBOCs)

The VISNs proposed 242 new CBOCs nationwide to address outpatient access issues, increasing workload capacity for primary and mental health care and space deficiencies at VA Medical Centers (VAMCs). The DNCP divided the proposed clinics into three priority groups. The Commission noted that the methodology used by VA generally led to CBOCs in rural areas being placed in the second priority group and left some markets with growing outpatient demand out of priority group one. We agree with the Commission's findings that, "... VA's rationale for prioritizing the implementation of new CBOCs was to control new demand for care, which disproportionately disadvantages rural veterans and is contrary to the goal of CARES." We believe the CARES process should be data driven and if VISN data supports the need, through market share analysis, for additional outpatient clinics, CBOCs should be established without regard to the priority group requirements outlined in the DNCP. It should be left up to Congress to authorize sufficient funding to meet the projected need for additional clinics.

MENTAL HEALTH SERVICES

Of great concern to DAV is the error in calculating the gaps in mental health services identified by VA mental health experts. Initially, we were pleased that the CARES office convened a special mental health workgroup which acknowledged the error represented an underestimation of future outpatient mental health needs by approximately 34 percent. Disappointingly, the corrections made by the workgroup and the revised projections still have not been run or distributed to the field. Mental health experts briefed the Commission on several occasions and provided detailed information about the problems this flaw in the model presents and the impact of erroneous data for future planning of mental health services. We are pleased the Commission acknowledged in its report this serious flaw in the model as well as the significant variation in the current provision of mental health services across the VISNs, including CBOCs.

We agree with the Commission's recommendations that the CARES data for outpatient mental health services and acute psychiatric inpatient care be corrected and forwarded to all networks as soon as possible so that VISNs can quickly identify and revise plans to address any gaps in service which should be integrated into the ongoing CARES process.

Additionally, VA should properly assess the need for outpatient mental health care space requirements and ensure VHA is providing needed mental health services in VA CBOCs. Based on VHA data, over 28 percent of users of VHA care have a mental health diagnosis and over 460,000 are service connected for mental health disorders, including posttraumatic stress disorder and psychoses. In fiscal year 2003, nearly 800,000 veterans used mental health services at VA facilities. Mental health services like long-term care services make up the core of specialized services within VHA. This particularly vulnerable population is at higher risk for being disenfranchised during the CARES process. Several of the sites under consideration for transfer or consolidation of services are in areas where there are specialized programs to treat veterans with complex mental health, substance abuse, and violent behavioral problems. In many cases, closure of a treating facility is devastating for these fragile patients and their families who have come to depend on these specialized programs. Can we ensure these veterans will be better served and have reasonable access to similar programs in a nearby location? In some cases, it may be more cost effective for VA but is the veteran patient best served? Disruption of long-standing treatment in a familiar facility can often lead to a setback for the patient with serious mental illness.

Given veterans' reliance on and need for these highly specialized programs, we urge the Secretary to include this critical care component prior to his decision and finalization of the CARES plan.

LONG-TERM CARE AND LONG-TERM MENTAL HEALTH CARE

The need for long-term care services, which includes nursing home, domiciliary, and non-acute inpatient and residential mental health services remains a complex issue. Initially, VA identified through its CARES model the projected need for more

than 17,000 additional nursing home beds to meet the future needs of aging veterans. Unfortunately, VA took this issue off the table and has not made a formal policy decision regarding the long-term care needs of veterans other than to say that VA will focus on alternate home health care options. VA's Under Secretary for Health has stated on several occasions that veterans do not want to be in extended care facilities, but rather prefer to receive care in their homes. Although this may be true, realistically, many veterans do not have a spouse or family member that can act as care-giver and many veterans will need the level of care provided in an institutional setting and will not be able to remain at home.

Additionally, it appears VA is adhering to the letter of the law, rather than the spirit of the law, related to extended care services, providing this type of care only to veterans with service-connected disability ratings 70 percent or higher or to veterans who need such care for their service-connected condition. Whenever possible, VA prefers to relegate long-term care services to the community in either State nursing homes, many of which are filled to capacity, or through State Medicaid programs. Unfortunately, VA has not been as diligent in its oversight of the quality of care provided in these alternate settings. Transfer of patients receiving extended care services to a nearby location can often be devastating to an elderly patient and his or her family. Elderly spouses or family members are often frail themselves and unable to drive long distances to see their loved ones. VA must also take into consideration that these family members may be unable to visit regularly and help assist their loved ones on a daily basis. Additionally, there is the issue of extended care services for patients with serious mental disorders.

Many VA patients with dementia and other complex mental health issues generally do not make good candidates for transfer to community long-term care nursing facilities. In many cases, the private sector is unable or unwilling to accept seriously chronically mentally ill patients, who are often difficult to manage. It seems incredible that VA has chosen not to include this portion of care services in CARES Phase II, given that long-term care is one of the most important and integral components of health care today. To leave this critical piece out of the CARES equation will only compound the problems associated with VA's capital asset planning and restructuring in the years to come. It is difficult to be supportive of the process when consideration of such a key component is left hanging. Of equal concern is that, although this issue was not fully addressed in the DNCP, there are proposals in the plan for closures and/or transfer or consolidation of services that directly impact on long-term care and mental health inpatient services. The DNCP includes proposals for consolidations or realignments with significant extended care components and construction of new extended care facilities in some locations. We also note that there is significant variability in the delivery and access to extended care services throughout the networks. The Commission notes that there seems to be inconsistency in proposals of where to locate long-term care facilities, i.e., placement of extended care centers near medical facilities or free standing. We agree that VHA should develop clear criteria for the placement of extended nursing home beds/units and that there should be uniformity and equal access to such services across the networks with a focus on quality of care.

We concur with the Commission's findings regarding long-term care. Specifically, that VA has not developed a consistent rationale for the placement of long-term care units, has not adequately addressed the needs of aging, seriously mentally ill patients, and that the proposal for movement of domiciliary beds is inconsistent with established programs.

The integral nature of the placement of domiciliaries and programs for homeless veterans, substance abuse treatment, and other specialized VA programs warrant additional study and consideration by experts in these unique program areas.

EXCESS VA PROPERTY

Dealing with identified excess VA property remains a complex issue. VA's plan is projected to result in a 42 percent reduction in vacant space over a 20-year period. VA identified in its evaluation process that it had approximately 8.5 million square feet of vacant space. In the VISN evaluations, space that was not utilized for patient care, support patient care or other VA missions, was identified as vacant. According to the DNCP, such space was proposed for demolition, divestiture or lease or enhanced-use lease (EUL) authorization agreements. The plan points out that demand for possible vacant space at VA facilities could change in the future based on a variety of factors, including changes in the economy or in the practice of health care delivery. VA pointed out that in many cases unused space is not appropriate for alternative use due to the specific location of the building in relationship to other campus buildings, i.e., the unused space may be located in outlying buildings or on

upper floors, therefore unsuitable for modern medical functions or attractive for other uses. The plan also notes that the savings, profits and costs associated with the management of vacant space is complex and difficult to standardize. According to VA, total savings from proposals such as closure of facilities identified in the DNCP have not been fully evaluated.

We agree with the Commission's findings that there was heavy reliance on EUL proposals in the DNCP and that the planning and the process, as it currently exists, have been fraught with delays and have led to significant lost opportunities. Although this program offers the best way to retain resources for direct patient care, improvements need to be made for the program to be more advantageous. We support the Commission's recommendation to reorganize and streamline the EUL program to best achieve VA's goals. The Commission also commented that maintaining buildings or excess land requires VA to utilize medical appropriations that could be used for direct patient care. We are extremely concerned about the sale of VHA properties and the reported requirement that such funds cannot be retained for patient care but must be returned to the Treasury.

DAV does not want to see resources that can be used for direct patient care used to maintain unused infrastructure or buildings that cannot be cost-effectively reused for providing medical services. However, we believe VA should be allowed to maintain funding from leasing or sale of these structures for patient care. VA should carefully consider its analysis of unused space and deal with it appropriately, keeping in mind that some space is located in historic structures and must be preserved and protected according to the law. When appropriate, space should be used for enhanced use lease for veteran-related programs.

CONTRACTING FOR CARE

The Commission found several benefits for contracting for care in the community, including additional capacity and improved access in a more timely manner than can be accomplished through a capital investment; flexibility to add or discontinue services as appropriate; and increased access in areas with smaller workloads, such as highly rural areas.

We recognize that contracting for care is sometimes necessary to ensure services are available. For example, when a veteran lives in a remote geographic location, or if VA has only a limited number of veterans that need care in a specific area, it is not always able to recruit or attract full-time clinicians to staff a CBOC. However, under such circumstances, VA should establish and adhere to strict guidelines when contracting for care to ensure continuity of care and proper patient oversight is maintained. To ensure high quality comprehensive health care services and continuity of veteran patient care, contracting for health care services should only occur when such services are unavailable in VA facilities, geographically inaccessible, or in certain emergency situations. The VA health care system was developed to meet the complex and frequently unique health care needs of veterans. Whenever possible, VA should be the provider of health care to our nation's sick and disabled veterans.

INFRASTRUCTURE AND SAFETY

Unfortunately, VA's construction budget has decreased sharply over the last several years with political resistance to fund any major projects before VA developed a formal capital asset plan. Many desperately needed construction and maintenance projects, including seismic repairs that could potentially compromise patient safety, have been unnecessarily delayed. DAV strongly believes that CARES should not distract VA from its obligation to protect its physical assets whether they are to be used for current capacity or realigned.

VHA identified 63 sites requiring seismic correction. The DNCP prioritized 14 sites that require immediate seismic strengthening. We agree with the Commission's recommendations that patient and employee safety is the highest priority for VA CARES funding and that VA should seek the funding necessary to correct the identified seismic deficiencies as soon as possible.

Any construction needed to repair seismic deficiencies or to ensure patient safety at VA health care facilities should be completed immediately on buildings identified through the CARES process to remain in the system for patient care. Careful consideration should be given to ensure that the most cost-effective plan is chosen if there is a need for renovation of older buildings. In many cases, it is more cost effective to build a new facility rather than conduct major renovations on an existing property. If space is not appropriate for its purpose, renovation plans will be larger and more inefficient and therefore cost more, not less.

RESEARCH, EDUCATION AND TRAINING

Without question, VHA provides the most extensive training environment for health care professionals and allows VA to provide top quality cutting edge health care services to our nation's veterans. Medical school affiliations are critical to VA's mission and they should be treated as partners in the planning and implementation stages of CARES. DAV, as part of *The Independent Budget* notes that VA has academic affiliations with 107 medical schools, 55 dental schools, and more than 1,200 other schools across the country. Each year, more than 81,000 health professionals are trained in VA medical centers. In addition to their value in developing the nation's health care work force, the affiliations bring first-rate health care providers to the service of America's veterans. The opportunity to teach attracts the best practitioners from academic medicine and brings state-of-the-art medical science to VA. Veterans get excellent care, society gets doctors and nurses, and the taxpayer pays a fraction of the market value for the expertise the academic affiliates bring to VA.

The Commission recognized the importance of education and training within VA but found that medical schools and other affiliates have not made the transition from traditional inpatient teaching modalities to community-based educational programs in VA. The Commission recommended that VA develop a plan to address this issue by adding a community-based component to VA's educational programs. DAV supports the Commission's recommendation.

SPECIAL DISABILITIES PROGRAMS

We are satisfied with the proposed placement of spinal cord injury/disorder (SCI) and blind rehabilitation centers in the DNCP. We concur with the Commission's recommendations to: (1) improve coordination between VISNs with regard to placement of special disability centers to optimize access to care for catastrophically disabled veterans; (2) develop new opportunities to provide blind rehabilitation in outpatient settings; and 3) conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds and reduce wait times.

VA/DEPARTMENT OF DEFENSE (DOD) SHARING

The DNCP proposed 75 collaborative opportunities for VA/DoD sharing. The Commission supported the recommendations of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans concerning this issue, and recognized VHA's vital role and fourth mission to act as the nation's primary backup to DoD in time of war or domestic emergency. Given the current State of world affairs, DAV considers this a critical part of VA's overall mission. We concur with the Commission that as the CARES process proceeds, careful consideration must be given to this function of the VA as it relates to VA's physical assets. As a nation, in the future, we may need VA's support if there are additional terrorist attacks levied at the American people. We must be prepared to deal with any given scenario and ensure not only the safety of our nation's sick and disabled veterans, but all our citizens. The VA health system is a natural safety outlet in this regard if given the proper resources and support to carry out this critical mission.

RESEARCH SPACE

As stated in *The Independent Budget*, VA medical and prosthetic research is a national asset that helps attract high caliber clinicians to practice medicine and conduct research in the VA health care system. The resulting environment of medical excellence and ingenuity, developed in conjunction with collaborating medical schools, benefits every veteran receiving care at VA and ultimately all Americans. We agree that research opportunities are an important component of VA health care and that the proposals outlined in the DNCP for enhancing research space should be carried out.

THE FUTURE

Finally, in Appendix E of the report, the Commission discussed problems it encountered relating to cost effectiveness analysis submitted by the VISNs. A team was assembled by the Department to help the Commission analyze the data but was not briefed on the methodology utilized in realignment studies conducted by the VISNs. The Commission noted that the team had to accept the cost estimates and workload projections provided, without an opportunity to verify them. The Commission noted that inconsistencies and errors in data were found in the proposals and could mislead decisionmakers unless a more detailed analysis is completed. The Commission stated that only a preliminary analysis of the cost effectiveness of the

proposals could be accomplished, given the extreme limitations on time available to complete the work.

This serves as one more example of the consequences of the aggressive schedule that VA maintained for CARES. On several occasions, DAV expressed concern about the compressed schedule for CARES Phase II. We support expeditious resolution of VHA's capital asset problems; however, we strongly urged VA to slow down and get it right the first time. After starting CARES Phase II, VA acknowledged problems in the model with respect to mental health, long-term care and domiciliaries. It chose to take these issues "off the table" and instead of developing solutions and extending CARES deadlines, VA chose to push ahead, stating that it would address these critical issues after CARES Phase II was completed, in its strategic planning process.

As this phase of the CARES process comes to a close, we watch with some trepidation the final outcome. In reality, this is only the beginning of CARES with future consideration of master implementation plans at the national and local levels, uncertainty of Congressional support and funding of the process, timeframes and priority for individual project development. DAV strongly believes that mandatory funding for VA health care is necessary not only to ensure that veterans receive timely quality health care but to ensure continuation of the CARES process and ultimately the viability of the VA health care system.

In closing, we thank the Committee for convening this hearing today and allowing DAV the opportunity to express our views on this important issue. Although the Commission had a daunting task, we are thankful that many of the concerns of veterans throughout the country have been heard and were carefully considered as the Commission completed its final deliberations. Although we agree with the Commission that the final plan should be national in scope, we hope there is sufficient consideration given to local concerns by veterans and other stakeholders as the Secretary issues his final decision. There should be sufficient cost-benefit analysis data to support any proposals on consolidations or transfer of services. Ultimately, the goal of enhanced health care services for our nation's sick and disabled veterans and proper stewardship of the VA health care system is our main concern on behalf of the nation's 2.6 million disabled veterans.

Finally, we agree with the Commission's recommendation to establish an independent advisory body, with appropriate charter and authority to monitor and advise the Secretary on the ongoing integration of CARES into VA's strategic planning process. Oversight by Congress, veterans, VSOs and other interested parties will be essential to success of this important initiative.

Chairman SPECTER. Well, thank you very much, Ms. Ilem.

We turn now to Mr. James Doran, National Service Director for AMVETS.

Thank you for joining us and the floor is yours.

**STATEMENT OF JAMES W. DORAN, NATIONAL SERVICE
DIRECTOR, AMVETS**

Mr. DORAN. Good afternoon, Mr. Chairman. On behalf of AMVETS National Commander John Sisler and the nationwide membership of AMVETS, I am pleased to offer our views of the CARES Commission report that has been submitted to the Secretary.

Generally, AMVETS supports the CARES process. We understand that, under CARES, the Veterans Health Administration is going to close some facilities and some employees will be lost. Our primary concerns here are two-fold.

Access to health care for veterans must be maintained and if reductions in force are required, we request that military veterans, and especially disabled veterans employed by the VHA be retained in all cases.

In the last century, Mr. Chairman, your father was wounded in action during World War I, denied his benefits by our Government and participated in the second veterans march on the Capitol. Captain Jeffords, Colonel Graham, Sergeant Miller, Airman Campbell,

Army Engineer Akaka and 25 million other of their comrades in arms must never be forced to suffer the same indignation as your father. That is one of the purposes of both this Committee and AMVETS.

There are flaws in the CARES Commission report, just as there are flaws in the draft National CARES Plan. The commission has addressed many of these flaws. AMVETS, on the other hand, has not had the opportunity to fully digest the commission report.

We do feel that any study involving excess or surplus property should consider all methods of divestiture, which I believe is the term they used in the commission, with the funds being retained by the VA, not being moved back into the Treasury for use in the general fund. We also would like to see, prior to closing any inpatient services at any facilities, that replacement care is in place and up and running before a closure takes place.

In developing sharing agreements between VA and DoD, we recommend that the agreements be signed by both the Under Secretary for Health and the appropriate service secretary. This would preclude military-base commanders from repudiating the agreement at a future date. AMVETS also does not want to see DVA-DoD joint clinics located inside the security fence at military installations. In case of increased defense conditions, these bases would be locked down and veterans would be denied access to care.

We would like to also express our thanks to Chairman Alvarez and his commission for all their hard work.

That concludes my testimony, Mr. Chairman.

[The prepared statement of Mr. Doran follows:]

PREPARED STATEMENT OF JAMES W. DORAN, NATIONAL SERVICE DIRECTOR, AMVETS

Good Afternoon Mr. Chairman and Ladies and Gentlemen of the Committee. IOn behalf of AMVETS National Commander S. John Sisler and the nationwide membership of AMVETS, I am pleased to offer our views of the CARES Commission Report to the Secretary of Veteran Affairs.

For the record, AMVETS has not received any Federal grants or contracts during the current fiscal year or during the previous 2 years in relation to any of the subjects discussed today.

Mr. Chairman, AMVETS has been a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces. Today, our organization continues this proud tradition, providing not only support for veterans and the military in procuring their earned entitlements, but also an array of community services that enhance the quality of life for this Nation's citizens. Title 38, United States Code, Section 1710 states that "The Secretary shall furnish hospital care and medical services which the Secretary determines to be needed to any veteran for a service-connected disability and to any veteran who has a service-connected disability rated at 50 percent or more." The Statute delineates, in more detail, to whom the Secretary shall furnish hospital care and medical services. The CARES Commission reports that "Access and Quality of Care should be the primary drivers in recommending changes to meet the health care needs of veterans."

Generally, AMVETS supports the CARES process. However, we feel that in some Veterans Integrated Service Networks, the needs of the veteran may not be the primary focus of local, mid-level, management.

We understand that, under CARES, the Veterans Health Administration is going to close some facilities. They may increase the services at other facilities, open additional Community Based Outpatient Clinics, or utilize contracted health care to replace closed facilities. Some employees will undergo a Reduction in Force, others will be transferred, and still others will be offered early retirement. Our primary concerns here are twofold. Access to healthcare for veterans must be maintained. If Reductions in Force are required, we request that military veterans, and especially disabled veterans, employed by the Veterans Health Administration, be retained in all cases.

In the last century, Mr. Chairman, your father, wounded in action during World War One, was denied his benefits by our Government and participated in the Second Veteran's March on the capital. Senator Murray's father, a wounded and disabled veteran of World War Two; Navy Captain Jim Jeffords; Air Force Lieutenant-Colonel Lindsey Graham; Marine Sergeant Zell Miller; Airman Second Class Ben Campbell; Army Engineer Danny Akaka; and their 25 million plus comrades-in-arms must never be forced to suffer that same indignation. That is one of the purposes of both this Committee and AMVETS.

There are, I'm sure, flaws in the CARES Commission Report, just as there are flaws in the Department of Veteran Affairs Draft National CARES Plan. The Commission has addressed many of the Draft National CARES Plan's flaws. AMVETS, however, has not had the opportunity to fully digest the CARES Commission Report. Yet, we do disagree with a few of the Commissions recommendations:

1. "... any study involving excess or surplus property should consider all options for divestiture, including outright sale. . ." An outright sale of VA property would cause the VA to lose money. Enhanced use of the properties enables VA to use rental revenues to bolster their budget. Outright sale currently requires that funds realized go to the US Treasury for deposit into the General Fund. An outright sale of VA property would prove to be detrimental to the veteran community.

2. Prior to closing any inpatient services in Altoona, Butler, and Erie, PA, VA must ensure that local hospitals are contracted to provide that care. Travel time for many of the veterans served by these facilities, and that of their loved ones, between their homes and Pittsburgh could prove to be detrimental to their care.

3. In developing sharing agreements between VA and the Department of Defense, we recommend that the agreements be signed by the Under Secretary for Health and the appropriate Service Secretary. This would preclude military base commanders from repudiating the agreement at a future date. AMVETS also does not want to see DVA/DOD Joint Clinics located inside of the security fence at military installations. In case of an increased Defense Condition these bases would be "locked down" and access to health care denied to veterans.

The FY2004 VA appropriation gives the Secretary authority to transfer up to \$400 million to CARES construction from VA's medical care account. AMVETS would like to see the Secretary pursue an aggressive, accelerated construction program in order to upgrade and improve the efficiencies of VA health care delivery as soon as possible. A moratorium has been in place awaiting the conclusion of the CARES process and such an acceleration would help move VA more quickly to a system where every dollar of the budget is better used to improve access and quality of care. We would, however, trust that the Secretary would not proceed on an accelerated schedule until the backlog of veterans waiting 6 months or more for their first doctor's appointment is fully eliminated. In any event, since the Administration's fiscal year 2005 budget request projects a carryover of approximately \$800 million of medical care resources from this year's budget to next year's, AMVETS fully expects that accelerating the CARES facilities recommendations should not have a negative affect on the delivery of veterans health care. Certainly with that much cushion in the Secretary's healthcare budget, we might expect not only an accelerated enhancement of facilities, but discontinuance of the ban on Priority 8 veterans access to the system.

Mr. Chairman, as I previously mentioned we have not been able to fully study the CARES Commission Report. The areas I've mentioned are just a few examples of items with which AMVETS is concerned. We are more than willing to provide this Committee with a full, written, comment sheet in the near future. We would like to express our thanks to Chairman Alvarez and his Commission for all of their hard work. AMVETS acknowledges that the Veteran Health Administration has a strong need for capital improvements. However, we would like to remind the Committee that although the VA provides some of the best health care in the Nation, the quality of care is insignificant if the veteran cannot access that care.

AMVETS National Executive Committeeman from Ohio, J.P. Brown III, summed up our view at a CARES Commission hearing, last August, when he said, "[The VA does] . . . a good job with the resources available to them. I encourage you to support this next step. It is an important advance in addressing the physical facilities of the VA. . . . and providing the resources that are needed to keep America's promise to veterans."

Mr. Chairman, that concludes my testimony.

Chairman SPECTER. Thank you very much, Mr. Doran.

Our final witness is Mr. Fred Cowell, Health Policy Analyst for the Paralyzed Veterans of America. The floor is yours, Mr. Cowell.

**STATEMENT OF FRED COWELL, HEALTH POLICY ANALYST,
PARALYZED VETERANS OF AMERICA**

Mr. COWELL. Mr. Chairman, Members of the Committee, PVA appreciates this opportunity to share some of our observations concerning the CARES Commission's final report that is designed to realign the VA's health care system.

In the interest of the Committee's valuable time, I will be brief and focus on those recommendations that have the most significant implications for veterans with spinal cord injury or disease.

PVA is pleased to see the CARES Commission recognize the importance of expanding VA's spinal cord system of care by calling for four new SCI centers in VISNS 2, 16, 19 and 23. However, PVA would like to point out that the commission also supported the establishment of a new SCI center in VISN 4, but this recommendation did not appear as written language in the final report. A new SCI center in VISN 4 will greatly enhance access to VA SCI services for thousands of East Coast veterans, especially for those who live in Pennsylvania, Delaware and northern Maryland.

In the area of SCI long-term care, PVA supports the commission's recommendations for adding long-term care beds in VISN 8, 9, 10 and 22. These beds represent a significant first step toward solving the long-term care demand crisis that is looming for aging veterans with spinal cord dysfunction.

Regarding new SCI outpatient clinics, PVA would like to point out the importance of VA establishing an SCI outpatient clinic at Castle Point as the Bronx SCI consolidation takes place, the need for a new multi-specialty outpatient clinic in the Las Vegas area that includes spinal cord injury, and the commission's recommendation for an SCI outpatient clinic to be established in VISN 4 at the Philadelphia VAMC.

When considering facility closures, PVA is concerned with the commission's recommendation to study the feasibility of constructing a new mega-hospital in the Boston area, VISN 1. If this new hospital were to become a reality, it would displace thousands of veterans and result in the closure of VA's SCI center at West Roxbury and the designated SCI long-term care facility at Brockton. PVA feels that other commission closure or mission change recommendations must be guided by the principle that access and quality of VA health care will be improved by their development.

Mr. Chairman, this concludes my remarks.

[The prepared statement of Mr. Cowell follows:]

**PREPARED STATEMENT OF FRED COWELL, HEALTH POLICY ANALYST,
PARALYZED VETERANS OF AMERICA**

Mr. Chairman and Members of the Committee let me begin by thanking you for your continued advocacy on behalf of our nation's veterans. Paralyzed Veterans of America.

(PVA) greatly appreciates the commitment of this Committee and your staff and thank you for your willingness to hear our concerns and work with us to find solutions.

Now that the CARES Commission has delivered its final report, I would like to share with you a few observations we have made about the Commission's recommendation before you make your own final decisions concerning CARES. For the purpose of this hearing and throughout the entire CARES process PYA has focused on those elements that have implications for the availability and quality of care provided veterans with spinal cord injury or dysfunction. Clearly, we are very pleased

to see that the Commission is supportive of expanding VA's Spinal Cord System of Care by recommending new SCI Centers in four VISNs and adding, much needed, additional long term care capacity in four others.

In the spirit of providing the very best care for those veterans with spinal cord injury, we offer the following observations for your consideration:

NEW SCI CENTERS RECOMMENDATIONS

As stated previously, PYA is pleased to see the Commission's recommendations for the addition of four new 3D-bed SCI Centers in VISNs 2, 16, 19, and 23. These new Centers will greatly improve access to VA SCI services in these areas of the nation.

However, PYA would point out that while there is no final Commission report recommendation language to add a new SCI Center in VISN 4, Chairman Alvarez said, at the conclusion of the CARES final report briefing on February 13, 2004, that "the Commission supported a new SCI center in the southeastern portion of VISN 4." PYA strongly supports this verbal Commission recommendation and believes the CARES projection model clearly supports the need for an additional SCI Center in VISN 4.

PYA also supports the Commission's recommendation for additional study concerning the appropriate location for the new SCI Center in VISN 16. The Draft National Cares Plan (DNCP) supported the North Little Rock facility but the Commission recognized that North Little Rock did not provide the full range of tertiary care services required by VA to be a proper site for an SCI Center. Additional analysis is also needed for the proper location of a new SCI Centers in VISN 4. During this study phase, preceding implementation, PYA has also requested that VA review the CARES model for VISN 11 to find ways of enhancing SCI services in this geographical area.

SCI LONG-TERM CARE RECOMMENDATIONS

PYA believes that the CARES Commission's recommendations for adding SCI long term care beds in four locations in VISNs 8, 9, 11 and 22 represents a significant first step toward solving the long-term care demand crisis that is looming for aging veterans with spinal cord injury or disease. Currently, VA has only four dedicated SCI long-term care facilities and three of these are on the East coast. These facilities are located at Brockton, MA, Castle Point, NY, Hampton, VA, and at the Hines Residential Care Facility in Chicago, IL and combined only have a total number of 125 staffed beds. SCI veterans living west of the Mississippi have no access to a dedicated specialized SCI long-term care facility in their part of our country. When possible, PYA believes that the most ideal location of a dedicated SCI long-term care facility is adjacent to or in close proximity to an SCI Center. While the Commission recommends further VA study for the exact location of SCI long term care beds in VISN 8, PYA still believes that the Tampa SCI Center is the proper location for these much needed beds. During the construction phase of the SCI Center in Tampa the footprint for construction included plans for the later addition of an SCI long-term care wing. PYA recommends that VA take advantage of its advance planning and locate these 30 long-term care beds in conjunction with the Tampa SCI Center.

PYA supports the Commission's long-term care recommendations to add 20 SCI long term care beds in Cleveland, 20 SCI long-term care beds in Memphis and 30 long-term care beds at Long Beach. However, PYA does not support sacrificing acute SCI bed capacity to accommodate the 30 bed SCI long-term care bed addition at Long Beach. From the beginning of the CARES process, PYA supported the activation of a now vacant SCI ward at Long Beach to meet this need.

Additionally, PYA would like to revisit a significant problem concerning the difference between acute SCI Center care and SCI long-term residential care, that evolved as the CARES Commission process moved forward. As the Commission continued its fact finding work it became clear to PYA that the Commission had blurred the distinction between acute SCI Center care and SCI long-term residential care.

As the Commission made investigative visits throughout the VA health care system, some members of the Commission were concerned with their observations concerning low occupancy rates at SCI Centers. In fact, the Special Disability Program section of the Executive Summary of the Commission's final report quotes current occupancy rates among VA facilities with SCI/D units as ranging from approximately 52 percent to 98 percent. PYA feels it was this impression that led the Commission to think of ways to fill unused SCI Center beds with SCI long-term care need. PYA has just completed reviewing VA's SCI Center Staffing and Bed Survey

Reports of SCI centers for the twelve months of 2003 that we would like to share with you.

This analysis shows occupancy rates in 2003 at SCI Centers range from 65 percent on the low end to 121 percent on the high end. PYA would also like to point out that a census of SCI utilization taken on the last day of the month, often a Friday, can result in a lower average number. Also, the SCI census in many SCI Centers is artificially lower than patient need due to a lack of staffing in many facilities. We are not sure how the Commission arrived at their occupancy rates but would be happy to discuss our methodology at your convenience.

Upon review of the Commission's final report it is clear that the Commission did not grasp the differences between these two modalities of care and felt that a mixing of these services could be easily accomplished. Once again PYA believes that the mixing of SCI acute care beds and long-term SCI residential care beds (nursing home beds) in SCI Centers is improper. PVA feels that re-designation of acute SCI Center beds to long-term care is not in the best interest of SCI veterans. PYA feels that an acute SCI hospital inpatient setting is not a home-like environment and is the wrong location to place an aging SCI veteran. PYA is concerned that SCI Center placement would expose these frail SCI veterans to a number of medical risks that would further jeopardize their health.

NEW SCI OUTPATIENT CLINICS

PYA supports Castle Point to become an SCI Outpatient Clinic upon completion of the Bronx expansion and consolidation of SCI services. This SCI Outpatient Clinic at Castle Point was included in the DNCP and was discussed during the Commission's final hearing but did not appear as a recommendation in the final report. While the omission of this recommendation may simply have been an error created during the rush to finalize and print the final report document, PV A must draw this issue to your attention. PYA feels Castle Point must retain SCI outpatient services if the Bronx expansion is to be a success.

PVA's support of the Bronx consolidation was subject to VA maintaining current SCI services at Castle Point and East Orange until the Bronx expansion was completed. Upon completion, it was understood by PYA that East Orange would maintain its SCI Center role and that Castle Point would become an SCI Outpatient Clinic.

PYA supports the addition of an SCI Outpatient Clinic at Philadelphia in VISN 4, but strongly believes that a new SCI Center in VISN 4 is clearly needed to meet the SCI inpatient demand in this VISN. PYA also supports the establishment of an SCI outpatient clinic in the Las Vegas area.

FACILITY CLOSURES

PVA must express its serious concern with the Commission's recommendation to close Brockton, West Roxbury, Jamaica Plain, and the Bedford VAMC in favor of building a new VA facility in the Boston area of VISN 1. The financial commitment for this recommendation is enormous not to mention the displacement effect this recommendation would have on thousands of veterans. For SCI veterans it would mean not only the closure of VISN 1's SCI Center at West Roxbury but also the closure of a designated SCI long-term care facility at Brockton. Obviously, a decision of this size will require years of careful planning if it is to be implemented.

Regarding other Commission recommendations that call for facility closures or mission changes, we hope the Secretary understands that these actions may have an effect on certain SCI veterans. For some PYA members, who live long distances from VA's SCI hub and spoke system of care or in rural areas, these VA hospitals represent their only health care option. If VA hospital closures come to pass, VA must take action to ensure the availability of VA inpatient hospital care to meet the health care needs of these affected veterans.

In closing, PYA would like to commend the members of the CARES Commission and the behind-the-scene members of VA staff for their hard work and dedication to improving access to VA health care for America's veterans. The Commission's recommendations for expanding VA SCI services are much appreciated.

PYA also appreciates this Committee's diligence and oversight of the CARES process, there cannot be too much openness and oversight as VA reorders its capital assets and charts the course for the provision of health care for the next twenty years. I thank you for the opportunity to present the views of PV A and we look forward to working with you in the future.

This completes my statement and I am happy to respond to any questions you may have.

Chairman SPECTER. Thank you very much, Mr. Cowell.

This Committee very much appreciates the participation of the veterans organizations, and I regret that my colleagues aren't here, but it is a very busy time. This was an extraordinary day. We customarily meet, as you know, in the Russell Senate Office Building, but when the votes came up we moved over here.

It wasn't easy to get this room and in getting the room, I had to make a commitment that we would be out by 5 o'clock because this room has to be set up for a major reception at 6 o'clock. But the least I can do is invite you to come to the reception.

[Laughter.]

Chairman SPECTER. That is also about the most I can do.

There are questions which we would like to propound for the record which we will submit to you. Your full statements will be made a part of the record and your testimony will be reviewed and very carefully weighed. As you know, we do a lot of work through staff and through the record, and we will be putting the CARES Commission report under a microscope. This Committee is not going to stand by and see veterans' care reduced.

I was a little surprised by the testimony in that, as to two of the Pennsylvania facilities, Altoona and Erie, they are not even speaking as to present recommendations. It leads me to question what the utility is if they are not going to really activate for many years into the future. By that time, circumstances may have changed, and we will be taking a fresh look at what goes on.

This Committee appreciates your strenuous efforts to protect the veterans and we are with you 100 percent. Thank you all. That concludes our hearing.

[Whereupon, at 5:01 p.m., the hearing was adjourned.]